JANUARY 1959

Mental Hospitals

Official Hospital Journal of
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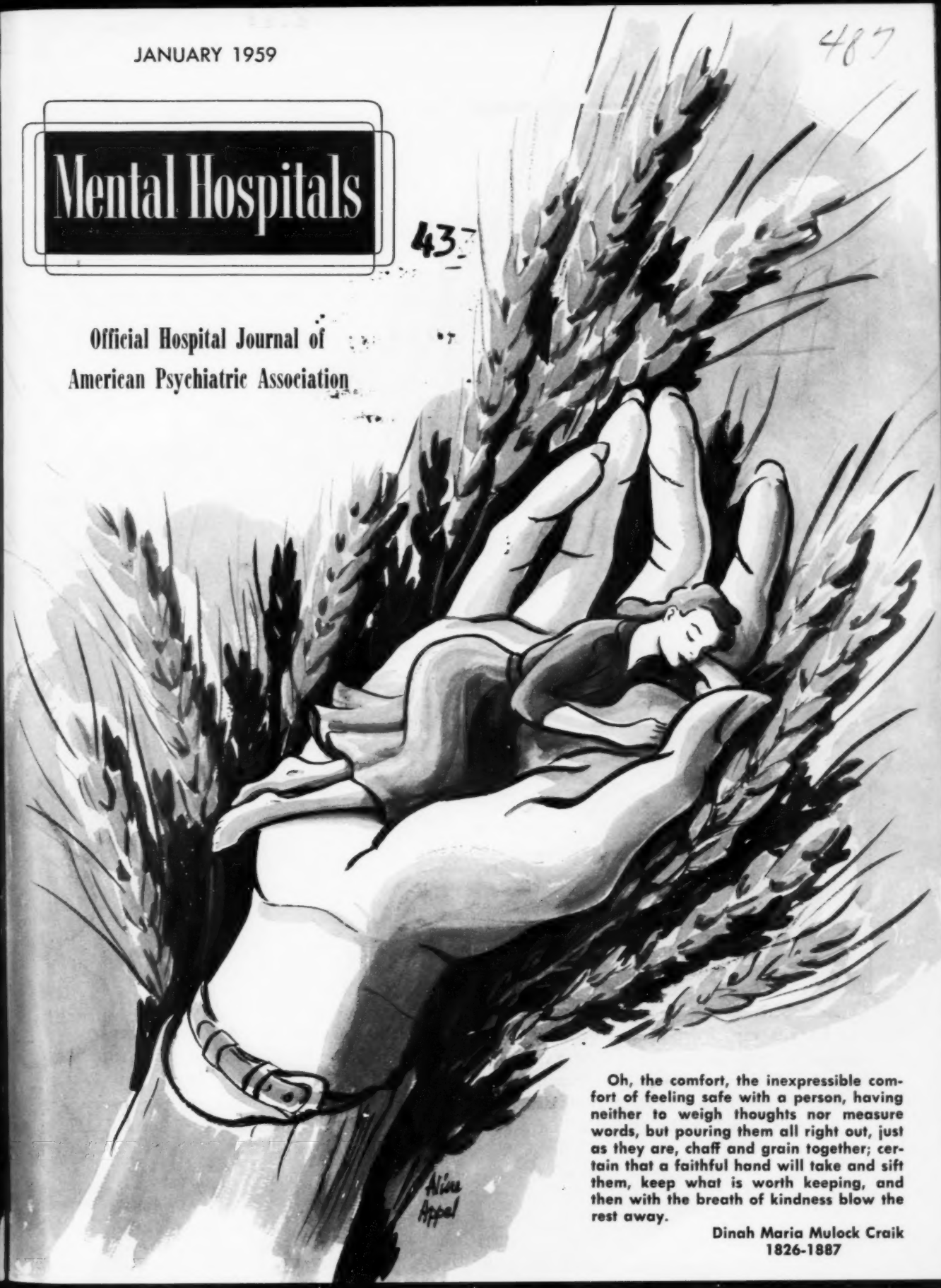

Oh, the comfort, the inexpressible comfort of feeling safe with a person, having neither to weigh thoughts nor measure words, but pouring them all right out, just as they are, chaff and grain together; certain that a faithful hand will take and sift them, keep what is worth keeping, and then with the breath of kindness blow the rest away.

Dinah Maria Mulock Craik
1826-1887

Mental Hospitals

VOLUME 10 NUMBER 1

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OFFICIAL HOSPITAL JOURNAL OF AMERICAN PSYCHIATRIC ASSOCIATION

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1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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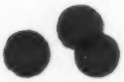

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PROFESSIONAL Feature Of The Month

THE PSYCHIATRIST AND THE NURSE

A WORKING PARTNERSHIP

I: The Sharing of Responsibility

By HUGH ADAMS, M.D., Chief of Professional Education

Camarillo State Hospital, California

APPROPRIATE as current emphasis on a multi-disciplinary approach to the care of the psychiatric patient may be, it is equally important not to overlook the fact that all of us engaged in such work are or should be of one purpose, moving toward a common goal. "Multi-disciplinary" is, in many ways, an unfortunate term, in that it may obscure the necessity for every member of the treatment team to acknowledge only one basic discipline, the treatment of the patient. Trees are not more important than forests, and consideration of special roles or technical abilities must not replace the concept of one team with one leader and one direction. There is good reason to doubt that the strivings sometimes observed among various medical and paramedical services will ever evolve to the point of greater service to the patient; indeed, such strivings may have altogether different motivations. Whatever the future may hold, there is certainly nothing in the present to indicate that members of this or that particular discipline can stand alone in providing psychiatric care, and the effectiveness of psychiatric ward care can still be measured in terms of how effective an understanding has been established between various workers. We shall concern ourselves briefly here with the relationship between the ward psychiatrist and ward nursing personnel, but most of the considerations will, of course, apply equally to the relationships between the ward psychiatrist and any other member of the treatment team.

Psychiatric Ward No Monarchy

Before attempting to define and examine this doctor-nurse relationship, one should first consider the situation in which the relationship occurs. Recent sociological studies of the structure of mental hospitals have challenged many of our traditional notions, particularly that one which held that an individual psychiatric ward constituted a kind of absolute monarchy, absolute authority being vested in the ward psychiatrist. Official or titular authority he ordinarily does have, but this is very different from that unofficial but actual authority which really "cuts the mustard." Authority for this or that particular function may have been parlayed by its holder into such strength that the ward psychiatrist may find policies or procedures blocked at points where he had anticipated no resistance.

Much of this assumption and manipulation of authority goes on outside the ward proper, so that ward personnel may find it especially frustrating. A nursing supervisor, for instance, can shift key personnel from one ward to another. A clothing room supervisor can give or withhold stature for a ward by sending clothes that are new or worn. The maintenance worker can raise or lower the level of tension among a group of patients by the speed and attitude with which he attends to a sluggish commode or a dripping faucet. A finance officer may find budgetary allotments for phenothiazine drugs but not be able to find the same amount of money, even though it all comes from the same general operating fund, to buy an electric stimulating machine or soundproofing material for an interview room. Since tradition and practice have tended to designate as non-medical many of the above-mentioned functions, the ward psychiatrist may find it easy to maintain his disassociation from them; these, he may easily say, are dietary or financial or maintenance or nursing problems and therefore none of his proper concern.

But in point of fact, since we do not know all the factors which do play a part in the genesis of or recovery from a psychiatric illness, we cannot say what things do not play a part. So far as we now know, anything happening to the patient or in his environment may be a critical factor in the illness for which we propose to treat him. Whether or not the psychiatrist has authority to regulate these various events he must, if he is to fulfill his role as leader of the medical team, assume responsibility for all of them. Should he allow himself to become involved in the struggle for authority, he will be entering an encounter he cannot but lose. His position is like that of the elected official who may be recalled at any time by the electorate; he will find his support withdrawn as soon as he begins to function from an authoritarian position. On the other hand, no one else wants responsibility, so if the ward psychiatrist will but indicate his willingness to assume it, he will find it being thrust upon him from all directions. This is as it should be, for of all the members of the treatment team the psychiatrist should be the one best fitted by training and experience to assume the greatest responsibility. Only on this acceptance of leadership can he base any claim to leadership, and the only actual authority he will have will be that which comes to him by virtue of this acceptance.

Ward Nurse Provides Liaison

The ward nurse should be the liaison between the rest of the treatment team and the patient, and in this position she has tremendous responsibility for maintaining accurate two-way reporting. She must carry to the patient the knowledge and thinking of the therapist group,

whether it be in the form of a medication, an activity prescription, or a limitation of activity. As the team member with greatest opportunity to observe and know of the actions and needs of the patient, she must communicate these observations and bits of knowledge to the other team members with the least possible distortion from her own prejudices or personal needs. The ward psychiatrist may sometimes have to modify his position as a scientist in the practice of his art, but the psychiatric nurse is allowed the pleasure of pure science, observing and collecting information and translating it into functional knowledge. When she so functions, she will not have to concern herself with whether she is being accorded proper professional respect; she will have assured professional status for herself. If the ward psychiatrist has accepted his true responsibility for the ward, the nurse will be freed to carry out these, her proper duties. Interestingly, when she is relieved of the terrible responsibility that is so often unloaded on her, she no longer has need for a protective armor of assumed authority and can "lend" this to the ward psychiatrist. On a ward where these attitudes are part of the therapeutic armamentarium, even Dickens' bibulous midwife, Sairey Gamp, could become a good nurse; working without such attitudes would try the mettle of a veritable Florence Nightingale.

The greatest barrier to an effective working relationship between nursing personnel and the ward psychiatrist is blame. "Whose fault is it?" is, in the psychiatric setting, practically incompatible with "How much will it help?" The doctor may take up with the nurse in very private conference his feeling that she is not pulling her share of the load, but in public he must remember that the leader of a team is responsible not only for the integrity of the team but for each of its members. Unfortunately "standing behind the nurse" has too often come to be nothing more than hiding behind her skirts.

Almost equally dangerous is the pitfall of trying to define the relationship between doctors and nurses in terms of rituals. Who stands while who sits, who goes through the door first, who smokes where, and the like, are now little more than maneuvers for camouflaging blind spots about competition, insecurity and hostility. Rigid rules about social intercourse away from the ward fall into this same category of avoidance by ritual of situations that cannot be faced directly. To show respect to someone who has earned it, doctor or nurse, is a dignified and satisfying experience; to pretend that ritual is respect is sham and degrading. The doctor or nurse who has the care of his patients as his only major concern while he is on the ward will have all the respect he can tolerate.

Power Struggles to Be Avoided

For the ward psychiatrist to become responsible for the total care of his patients is the only practicable way for him to avoid becoming involved in a power struggle, and avoidance of power struggles is the essence of the establishment of an effective and mutually rewarding relationship between the nurse and himself. The search for responsibility lights this path, the search for power darkens it. *The doctor and nurse who have not learned that the patient is their master and the only master they can serve will not become an effective team,* no matter how many papers they read or conferences they attend or tables of organization they construct. The doctor and nurse who know their position of servitude to the patient have already become an effective team, and professional stature and accomplishment will be their rewards.

II: The Common Goal of Treatment

By LORRAINE L. HEDMAN, R.N.

Nebraska Psychiatric Institute, Omaha

MUCH HAS BEEN SAID and written about the need for communications between members of the psychiatric team working toward the common goal of treating mentally ill patients. Certainly if nurses and psychiatrists are to blend their efforts toward the betterment of patient care, they need to have an understanding of each other's problems and why these problems arise. Otherwise the patient is apt to be caught in the middle and his progress jeopardized because of an interdisciplinary conflict which could have been resolved by effective communication.

At the Nebraska Psychiatric Institute, residents in training come from Holland, France, Norway, Puerto Rico, India, Great Britain and other countries, as well as from the United States. It is not surprising that each has his own ideas of the nurse's role in working with doctors, as well as his own concepts regarding the nursing care of psychiatric patients. Many of these residents come from countries where women and nurses have little status and are not accepted as co-workers. As a result many problems arise.

In a nursing staff meeting one nurse exclaimed wearily, "If we could only talk it over with them!" As a result the nursing director met with the clinical director of the adult inpatient service, to which first-year residents are assigned, and together they set up a schedule of regular meetings of the nurses with the residents. The purpose of these meetings was to provide an opportunity for each resident to explain his treatment plans and goals for his patients, and for the nurses to describe the behavior they observed and their feelings about the patients.

Each of the residents, individually, met with the nurse supervisor, two head nurses and selected staff nurses and aides. The meetings were held biweekly for one year,

and a total of eight residents attended in rotation. The resident discussed the factors which had brought his patient to the hospital, outlined plans for treatment and the anticipated goals of therapy. The nurses discussed the patient's adjustment to the hospital and described specific nursing problems relating to his care. The meetings moved slowly at first but soon both large and small problems involving the patient's behavior and care were brought out. Together psychiatrists and nursing personnel set up a plan of care that would be therapeutic for the patient.

One nurse described a patient who had become silent and sullen with occasional sarcastic outbursts. The resident explained that in his interviews with the patient he had discussed problems which probably had made her angry on the ward. When the ward personnel understood the patient's need to do this, they accepted her behavior better and handled the problem in a way that was more helpful to her recovery. One aide said, "When Miss K. got angry, I got angry too because I didn't see any reason for her to act that way. Her anger doesn't bother me as much now."

Treatment Approach Worked Out

One meeting centered on a nineteen-year-old man recently admitted. He was withdrawn, negativistic and unkempt in appearance. The nurse had the aides give him complete physical care to which he responded with strong resistance. During the meeting, the psychiatric resident explained that when this patient had neglected bathing, dressing or shaving at home, his parents had done these things for him. The nurse said, "It seems as though our nursing personnel are playing the same role which his parents played." The resident and nurses then worked out another approach to arouse the patient's interest in his personal appearance. He was encouraged to make his own decisions and carry out his own personal hygiene and grooming. None of these things were done for him and the head nurse helped her staff handle the anxiety they experienced when the patient at first appeared unresponsive.

Several days after the change in approach she said to the patient, "I believe that you would like to shave yourself today, wouldn't you?" After some thought the patient asked timidly, "Do you mean I can have sideburns?" The nurse said, "Yes, if that's what you want." From that time on the patient shaved himself and, as he gradually began to take an interest in his hygiene and grooming, he showed less negativism and resistance. Because the personnel understood how important it was for the patient to do things for himself, they appreciated the effort which he was making and this understanding helped in his treatment.

Nurses Describe Ward Problems

In another meeting the doctor discussed his relationship with an adolescent patient, explaining the limits he had set and why they were necessary. The nurses seemed greatly relieved, saying, "We didn't know how you felt about limits. We found we too had to set limits, but didn't know if we would have your support." The consistency of approach made possible because the nursing staff was aware of the resident's feelings about limits for this young boy led to the patient's beginning to work through some of his difficulties.

Another problem solved by discussion concerned a woman patient who often missed her breakfast because she did not arise when awakened in the morning. She complained to the nurse, who explained that the dining room closed at eight o'clock. The patient next complained to her doctor that she was not served breakfast and he, being a new man and unfamiliar with the policies of the nursing and dietary services, wrote an order: "Serve patient breakfast on the ward." Feelings ran high until the resident and the nurses discussed this situation at their regular meeting. It quickly became evident that the patient was playing one against the other in much the same manner as she had played one member of her family against another. The doctor and nurses agreed to tell the patient that she might sleep later if she preferred but that if she missed her breakfast, none could be served her on the ward. Within a few days the patient began rising and going to the dining room, and this initial move toward accepting more responsibility for her own actions enabled her to accept responsibility gradually in other areas.

The nurses soon felt free to question a doctor's order if they felt the patient's safety was involved. For instance, one doctor wrote an order letting a patient on insulin treatment go home on a day when she had received a large dosage. When the nurse explained that this patient tended to develop sudden insulin reactions of a coma degree, the resident rescinded his order.

Again a nurse questioned a doctor's order permitting an acutely delusional patient to go home on a visit. The doctor explained that the patient's family had coped with these symptoms for some months prior to his hospitalization and that, while they knew that the symptoms were still present, they felt they could handle the visit and wished to do so. This information was reassuring to the nurse.

Attitudes Communicate Themselves

One instance disclosed with clarity how readily feelings are communicated. During a meeting a resident had said that he thought a certain patient's condition was "hopeless." A nurse communicated this feeling of futility to the rest of the nursing staff when she reported that plans were being made to discharge the patient to a state hospital. One aide exclaimed "But I like this patient! I'd like to try to help her," and maintained her interest in the patient until the transfer. However, an apathetic pall seemed to fall on the rest of the nursing staff, and their care of the patient became merely custodial. They ceased to be alert for methods of reaching the patient or motivating her to increase her activity. Shortly before the transfer, the head nurse realized that the staff was isolating this patient, and used this as an example for teaching ward personnel the effects of negative feelings unconsciously communicated.

Sometimes a resident wishes to transfer a patient to a convalescent or open ward when the head nurse believes the patient is too sick to make the necessary

adjustment. In such an instance she may cite examples of the patient's behavior and interaction with others to support her belief that the patient is not ready for transfer. At first, some of the residents interpreted such evaluation as an expression of the nurse's hostility to the patient. After several such transfers had been made and the patients had to be transferred back to the closed ward, however, both doctors and nurses began to realize that unless there is staff agreement that a patient is ready for a more open environment, he is probably not able to adjust to it.

Nurses Gain Confidence

The support which the resident gives the nurses increases their self-confidence in making decisions. On one occasion a nurse expressed concern about a patient on the convalescent ward who was talking of suicide. The resident said that he would like to have that patient remain on the convalescent ward, but if at any time her behavior indicated a need for closer observation than she received there, he would support the nurse's transferring her immediately. For several days the head nurse was able to encourage the staff to continue to help the patient adjust to the convalescent ward. Then one day a psychiatric aide found the patient sitting rigidly in a chair staring at a silk scarf held tautly in her fingers. Without hesitation the nurse transferred the patient to the closed ward and the doctor subsequently approved her action.

Many of the meetings enable the nursing staff to obtain pertinent, accurate information about patients soon after their admission. This helps greatly in planning nursing care. In addition, the nurses' growth in understanding, confidence and optimism is a major factor in creating positive, helpful feelings in the entire ward staff.

These meetings are now a permanent part of our working together. We feel they result in improved patient care; more effective communication between psychiatric residents and nursing staff and between nursing staff and patients. Dr. William G. Hollister, in the May, 1954 AMERICAN JOURNAL OF NURSING, summed it up when he wrote "Perhaps the most meaningful advance we can make toward better human relations occurs when we ourselves grow beyond the need to conquer, to win others to our point of view. It occurs when our intent in relationships changes from one of conquest to a desire for togetherness."

Welcome, Brethren

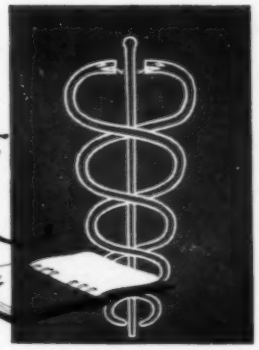
By DR. WHATSISNAME

THE OTHER DAY I was leafing through a number of annual reports from public mental hospitals. The high ratio of "foreign-sounding" names was impressive. This led to the next question: how would these hospitals have operated without our European and Asiatic colleagues? The answer is simple: they could not have operated—or they would have limped badly.

The alien physician is accustomed to taking it on the chin. He is excluded from many activities because he seems "foreign." He may be unlicensed, and thus be further excluded. His accent may be awkward, so that a communication difficulty develops. Visitors may be infuriated by this, or he may become the object of ridicule. Hospital administrators are often reluctant to promote alien doctors to high hospital rank simply because of citizenship, licensure or linguistic limitations. So, no matter how competent, he may have to remain in the lower grades of the hospital hierarchy.

There is no shortage of criticism here: either the administrators are criticized for appointing aliens, or the doctors are criticized for accepting such appointments. Yet no one seems to be expressing any gratitude for the fact that so many of our public hospitals simply could not operate efficiently without their assistance. They take their share of night duty and other hospital activities. They function as interpreters—a necessary role in our magnificently varicultured country. They keep us from becoming too provincial. They add a new dimension of experience to our staffs. Out of plain sportsmanship if nothing else, some one ought to say a good word about the alien physician—usually a man or woman driven half way around the world to escape tyranny; a man or woman who has faced poignant personal tragedy in his own life, and who has, at last, found peace with us. He more than pulls his own weight in the boat. Except for our Indians here, we Americans are all the sons, daughters, or grandchildren of immigrants. Welcome, brethren, welcome!

The Editor's Notebook



IDEAS HAVE LEGS, it has been said, and it is interesting to note that Dr. Adams (Page 7) and Mrs. Hedman (Page 8) had not read each other's articles nor had any personal contact. Yet Mrs. Hedman illustrates strikingly Dr. Adams' statement that the nurse must "observe and collect information and translate it into functional knowledge." And from their different viewpoints, both authors reach the same conclusion—that once the power struggle between doctor and nurse for status and authority is abandoned, the result will be a mutually rewarding relationship and a true partnership in working for better patient treatment, which is why we are in the act to begin with. I wonder if anyone would care to comment upon the nature of the "strivings between medical and paramedical services" mentioned by Dr. Adams. *What do you think they are*—what are the forces underlying them?

Mr. Middleton's article (Page 17) should arouse a good deal of interest. The rehabilitation of the aged patient is certain to be of increasing concern to all in the field of mental health. We'd like you to give continued thought to this whole question of aging. It is going to be an important part of the 11th Mental Hospital Institute program.

Dr. Brunt (Page 16) and Miss Surber and Dr. Niswander (Page 22) point to the contribution of patients in achieving the purpose of the mental hospital. Dr. Brunt underlines the value of the patients' contributions to true community understanding, as well as the therapeutic value to these patients and to their fellow sufferers. The patient's comments in the other paper raise the question—what is the value of an alcoholics-anonymous, confession-type approach to recovery from mental illness? Has anybody had experiences to share with us? Also, what are the "multiple processes" mentioned by these authors from the point of view of the psychiatrist, the nurse, the psychiatric social worker, the aide and others who work daily with the patient? We would much enjoy having *a ward team* write a cooperative paper on this subject. If you are interested, please write to the Editor, giving a brief outline and we'll let you know whether to go ahead.

Our colleague Dr. Goshen (Page 41) presents an unusual approach to the old problems of mental hospital design. What do you think of his module idea? Check it against the plans now on the drawing board for your hospital. Can anybody estimate the actual dimensions—both physical and staff—of a "psychiatric module" in his own hospital? I anticipate much discussion of this.

Another unusual approach—this time in the field of business management—comes up in Mr. Weston's article (Page 31). I sense the possibility of a lively debate arising on the subject of what kind of experience is most valuable to a hospital business manager.

QUOTES: On a factory in Birmingham, Alabama, I noticed the following sign: "You cannot do today's job with yesterday's methods and be in business tomorrow." Unfortunately for our patients, mental hospitals will not only stay in business but will continue to grow if we continue using "yesterday's methods." At the Annual Meeting of the NAMH in Kansas City, Dr. Harvey J. Tompkins, First Vice President, said in his keynote address, "An open hospital is an attitude which must be shared by staff and community." See Page 29 for Lois Jones' report on this interesting meeting.

During the A.P.A. Southern Divisional Meeting held at Miami Beach, on December 1st, 2nd and 3rd, President Francis J. Gerty not only received the keys to the city, but also delivered a scholarly Academic Lecture on the psychiatrist as a physician, in which he said "While the psychiatric physician cannot be something else than the need which created him, he cannot ignore the social changes that occur around him. It is not always remembered that we are physicians, not technicians. We must not give away our birthright."

NOTES: Glad to observe that new hospitals for the mentally retarded are planned in Erie and Suffolk Counties, New York. There are now almost 22,000 mental retardates in New York state institutions, nearly 145,000 country-wide. And let's stop calling these patients "children." The latest published N.I.M.H. figures show that only about one-third of these patients are 19 years old or less. Nearly one-quarter are over 40—all too many, alas, grow old in the hospitals . . . . Attended the first meeting of the Program Committee for the 11th Mental Hospital Institute on Monday, November 24th at the A.P.A. Central Office. Dr. Francis J. O'Neill, Central Islip, N.Y. is chairman of the committee, with Dr. Alfred Stanton, Boston, Mass., Dr. James E. Gilbert, Ottawa, Canada, Dr. William Hall, Columbia, S.C., and Mr. A. C. Yopp, Little Rock, Ark., to help us all plan for a new, and we hope, stimulating Institute in Buffalo, N.Y., October 20th through 22nd. Yes, the Institute will open on Tuesday, October 20th—this was not a misprint! The Institute is to be one day shorter, and Monday the 19th will be devoted to optional meetings.

Dr. Jack R. Ewalt told me that he and Dr. Harry C. Solomon finished their game of musical chairs officially as of December 15th. Harry became Commissioner of Mental Health, and Jack is now Professor of Psychiatry at Harvard University, and Superintendent of the Massachusetts Mental Health Center.

See Page 46, under "Current Studies" for three pertinent papers delivered during the A.P.A. Southern Divisional Meeting. Drs. Kris, Gatto, Gralnick, have generously consented to make copies available on request.

Matthew Ross, M.D.

PSYCHIATRIC PATIENTS ON THE WARDS OF A GENERAL HOSPITAL

By MARGARET HANOR, R. N.

The Mary Imogene Bassett Hospital, Cooperstown, New York

THIS 125-BED teaching hospital is situated in a small rural community. Its closed staff serves not only the residents of Cooperstown, but a large percentage of the residents of the county, and many from the surrounding counties. In addition, the hospital maintains a very active outpatient department. About 15 house officers are in residence and primary clinical experience is provided for students of nursing from a nearby college. There are six nursing units, one each for pediatrics, obstetrics, one male ward, one female ward, and two private or semiprivate units. Patients in the four latter units are not segregated according to services.

For a long time the need for some type of psychiatric service was recognized by the members of the staff of the hospital. There were no mental health clinics operating within the county. Accordingly in 1955 the hospital applied to the Commonwealth Fund and was awarded a grant to aid in the initiation of a psychiatric service. Dr. Hugh Adams joined the staff to operate the new service, which has been functioning for three years.

One of the first accomplishments was the setting up of a psychiatric outpatient department. This department has grown rapidly and now employs, besides the psychiatrist, one full-time and two part-time psychologists, a psychiatric social worker and two secretaries. In three years this department has seen 700 new patients.

As soon as the outpatient department was functioning, the problem of hospitalization for some of these patients had to be met. After considerable deliberation and planning on the part of the psychiatrist and Dr. James Bordley, III, the administrator of the hospital, it was decided not to group psychiatric patients in one ward, but to scatter them through the regular nursing care units of the hospital.

The non-agitated patient caused little difficulty to his ward-mates or the nursing personnel. However, he was apt to be slighted, due to the pressure of surgical and medical emergencies and also to the uneasiness of the general duty nurses regarding psychiatric patients. Agitated patients presented more of a problem, not only to fellow patients but to nursing personnel as well. Consequently it was recognized that a special nursing service should be established for psychiatric patients, and the author was appointed as the first nurse to be assigned specifically to this service. In time another nurse was added and the service became a busy but efficient operation, adequate to care for the eight psychiatric patients in the hospital. (Because of the large number of patients he cared for in the outpatient department, the psychiatrist on the service felt that eight inpatients were all he could treat properly.)

Neither of the nurses assigned to the psychiatric service had been specifically trained in this field, so a rather intensive educational program was set up for them. This included daily discussions of patients with the psychiatrist and the social worker; weekly Journal Club meetings where the entire psychiatric service met and each member reported any article he thought of interest or value; weekly meetings of the psychiatric team—psychiatrist, psychologist, social worker and nurses—where individual hospital patients were discussed; a weekly meeting known as Psychiatric Teaching Rounds, which was primarily for staff doctors, residents, interns and medical students, but which also provided the nurses with much information about psychiatry and its patients.

Patients assigned to the psychiatric service were admitted to the hospital by one of these nurses. This was a time to study the patient's reaction to the stress situation of hospitalization and his attitude towards his illness; to aid in his adjustment to the hospital; to observe the relationship of the patient to family or friends, and to give a good deal of reassurance both to patient and family. A routine physical work-up, consisting of a history and physical examination, routine urinalysis and blood count was done on admission by the intern in charge. Other tests or consultations, which the psychiatrist deemed necessary to rule out organic disease, were ordered subsequently.

Nurses Go From Ward to Ward

Being relieved of the pressures of general duty, the nurses on the psychiatric service could spend sufficient time with their patients to form relationships which would also aid the psychiatrist in learning more about the patients and their behavior patterns. The nurses went from ward to ward, wherever psychiatric patients might be, helping with their morning care, assisting them to dress, encouraging them to be up and around when able. Taking advantage of the facilities offered by the community, the nurses arranged trips and outings to local museums, theaters, etc. Picnic parties to the nearby lake, shopping excursions in the little town and a stop for a friendly cup of coffee were usually pleasant, often therapeutic. Badminton games and other outdoor activities on the hospital grounds were organized by the nurses, and enjoyed by the general hospital patients as well as the psychiatric group. It was indeed a pleasure to see the agitated or depressed patient respond to these group activities and begin to function and socialize in these groups.

Psychiatric consultations requested by medical, surgical, obstetrical-gynecological and pediatric services were numerous, and the psychiatric nurses, by their frequent visits to these patients, were often able to ascertain much about them that aided the psychiatrist. Although remaining on the other services, some of these patients were

taken over by the special nurses and given supportive nursing care during their stress situations.

One room of the hospital was taken over as the psychiatric treatment room. This room was used for patients receiving electro-convulsive therapy, insulin coma treatments, sodium amytal interviews, antabuse alcohol tests, lumbar punctures, etc. Insulin sub-coma treatment was done on the wards with a nurse in attendance. Some electro-convulsive therapy was also done in the patient's room. A cart, equipped with stimulator, a suction machine, oxygen with mask and bag for positive pressure, laryngoscope and emergency drugs, was wheeled to the wards or rooms of these patients. Sodium pentathol and anectine were given and the treatment was carried out with little uneasiness for the patient or his wardmates. It is interesting to note that patients in general showed no more interest in the electro-convulsive therapy cart than in a portable X-Ray or an EKG machine. In insulin coma treatment the patient was taken to the treatment room where the insulin was given and he stayed there until the treatment was terminated and breakfast had been served.

The special nurse has done much to make psychiatric service acceptable in this type of hospital. By taking the responsibility for these patients for eight hours a day, from 8 a.m. to 5 p.m., she has relieved the general staff of a great deal of pressure and tension which was felt when the service was first inaugurated. Discussion with other staff members about our patients, their problems and their needs, has alleviated much of the discomfort first evidenced at psychiatric admissions. The feeling of dismay on the part of the staff has now changed to a friendly interest of "What would you like us to do?" or "How can we help?"

It is indeed interesting to note the change of attitude of our medical staff and nursing personnel toward our psychiatric patients and the increased awareness of psychiatric symptoms in the medically or surgically ill. The number of requests for consultations from other services is still increasing as these services seek aid in diagnosing and caring for their patients more adequately.

A three-year period is not long enough to produce reliable statistics, but on the basis of the number of patients who have improved enough to return to their usual function in home and community, we feel that the program is more than worthwhile and one that will continue to grow. Psychiatric treatment in a general hospital is often much more acceptable to the patient and his family than commitment to a mental institution, and many serious psychotic breaks have been averted by the availability of early treatment.

We feel that this type of service provides one of the most challenging and gratifying experiences that a nurse can have. We also feel that our experience indicates that the small general hospital can provide adequate care for the majority of psychiatric patients.

Ed. Note: Dr. James Bordley, III, administrator of the hospital, advises us that this program has been temporarily interrupted due to the fact that on July 1, 1958, Dr. Hugh Adams accepted a position at Camarillo State Hospital in Oxnard, California, (see p. 7). Dr. Bordley writes, "We hope that in the near future a successor will be found to carry on this program."

Miniature Golf Course Has Local New England Flavor

When the New Hampshire State Hospital added a miniature golf course to its outdoor recreation facilities last summer, it eschewed the diminutive castles and windmills usually used for course obstacles and chose New England motifs. Two of the obstacles on "Pine Links" were copied from photographs published in an official state brochure called "This is New Hampshire"; one is a reproduction of the Baptist Church in Sandwich and the other is of Waterloo Bridge, a covered bridge over the Warner River.

The course has been crowded with players every fair day since the first nine holes were completed last September. Patients young and old enjoy it, and some of the players are persons who have never before entered into games, even as spectators.

The last nine holes of "Pine Links" will be completed next spring; the foundations are now being excavated by the Grounds Department. The completed course will have two ponds connected by a brook, as well as plantings of native shrubs, bulbs and flowers.

NORMAN B. BURBANK
Superintendent of Grounds

NEW STELAZINE* EFFECTIVE

IN LONG-TERM, "BACK-WARD" PATIENTS WHO ARE WITHDRAWN AND APATHETIC

"Previously withdrawn, sullen, and seclusive patients began to converse, take meals with other patients, and, in general, react to their surroundings."

Gunn, D.R.: The Role of Trifluoperazine in the Treatment of Refractory Mental Patients, in Trifluoperazine: Clinical and Pharmacological Aspects, Philadelphia, Lea & Febiger, 1958, pp. 47-53.

"... these patients, formerly dull, listless, lethargic and resistant to therapy, became active, ambitious, and productive in their work assignments, so that some could be released to active employment outside the hospital."

Brooks, G.W.: Definitive Ataractic Therapy in the Rehabilitation of Chronic Schizophrenic Patients: A Preliminary Report on the Use of Trifluoperazine, *ibid.*, pp. 54-61.

"One of the striking features of ['Stelazine'] is its dual capacity to act as an ataractic agent to calm aggressive patients and as a stimulant to stir passive, sluggish patients into productive activity and contact."

Kovitz, B.: Management of Psychotic Tension Symptoms with Trifluoperazine: A Preliminary Report, *ibid.*, pp. 144-149.

Available: Tablets, 2 mg., 5 mg. and 10 mg.
Multiple dose vials, 10 cc. (2 mg./cc.)

Literature available on request.

Smith Kline & French Laboratories (SKF) **leaders in psychopharmacology**

*Trademark for trifluoperazine, S.K.F.
(10-[3-(1-methyl-4-piperazinyl)-propyl]-2-trifluoromethylphenothiazine)

PATIENTS PROMOTE COMMUNITY RELATIONS

By HARRY H. BRUNT, JR., M.D., Medical Director
New Jersey State Hospital at Ancora

The Ancora State Hospital admitted its first patient on April 4, 1955. From that time onward we have been conducting an active community relations program so that the people of the eight counties we serve will recognize our hospital as a medical center and accept our patients as desirable neighbors and citizens.

Probably the most active and effective workers in this program are the patients themselves. They serve as tour guides and discussion leaders for visiting groups. They handle a heavy load of individual visitors, such as reporters, relatives who wish to inspect the hospital before a member of the family is admitted, boards of county officials whose appropriations maintain patients in New Jersey hospitals, and even the gentleman who showed up unexpectedly one day and said, "I am a taxpayer. I want to see how my money is used."

These patients also conduct regular group orientation sessions for newly admitted patients at the hospital, and serve as speakers and discussion leaders at important meetings in the community.

Naturally it is not easy at first for a patient to face the public and identify himself. Our patients usually work in groups. Moreover, those participating in the community relations program have two common characteristics. First, they are patients who enjoy a warm and satisfactory relationship with their personal therapists; secondly, they come from the ranks of a large group of patients who, as part of their treatment or training here, are employed in responsible positions in our administrative and executive offices. In this work they are exposed to public traffic and contact and begin to develop social ease in meeting people. After a certain period their social thresholds advance sufficiently for them to do public relations work.

Visitors Ask Many Questions

The questions that are uppermost in the public's mind deal with the nature of people who are mentally ill. Not only do our patients superbly answer such questions, but their poise, courtesy, and attractive appearance provide an answer much more eloquent than the spoken or printed word. They possess a vast fund of information and useful philosophy, which they have acquired as a result of their deep personal experiences and their backgrounds of intensive therapy.

There are, of course, limitations. Some of the questions pertain to matters with which our patients have had no experience—geriatrics or mental deficiency, for instance. However, generally speaking, they are able to cope with most inquiries.

The more dramatic aspects of this program were demonstrated when two groups of ten patients left the security of the hospital to appear at public meetings. The technique for such meetings is simple. The chairman arranges the audience in conversation groups or in a circle, encourages questions, and lets the patients take over.

I attended one of these meetings as an unnoticed observer. Members of the audience of ninety people engaged the patients in a stimulating three-hour discussion, and left at the end of the meeting with an appreciation and understanding of the patients and our hospital such as they could have gained through no other technique. The patients in turn acquired a noticeable increase in self-confidence and morale.

In one way or another all of the patients engaged in the community relations program have reported to us that they are much less self-conscious about being mental patients. Moreover, during weekend leaves and upon release they feel more competent to deal with the inevitable questions and social problems arising from their hospitalization.

Not only is this therapeutically valuable, but it has been our universal experience that both the public and the patients thoroughly enjoy these joint activities.

1959 ACHIEVEMENT AWARD CONTEST OPENS

Entries for the 1959 Mental Hospital Service Achievement Award competition will be accepted between January 1 and April 15. The competition is open to all psychiatric institutions, public and private, and to official mental hospital agencies.

The judges of previous competitions have recommended that the Awards continue to focus on clinical or administrative achievements within a hospital or geographical unit (city, state or province) which improve a specific area of hospital operation or produce over-all improvement. Particular attention will be paid to those projects which use imaginative means to achieve results, which make maximum use of minimum resources or which develop procedures that can be applied elsewhere. These achievements should be "above and beyond the call" and not merely improvements made in the normal line of duty.

Each hospital may submit one entry a year. It should be no longer than six double-spaced typewritten pages. Four copies of the entry and four sets of supporting material, if any, are required. Be sure to include the name and address of the hospital or agency and the name of the director.

Entries should be addressed to: Achievement Award Contest, A.P.A. Mental Hospital Service, 1700 Eighteenth Street, N.W., Washington 9, D. C.

In line with the policy established last year, the winning entries will be announced at the Eleventh Mental Hospital Institute in Buffalo, N.Y., in October. Presentation of the Awards will be made at the Institute Banquet.

A Nursing Home and Follow-up Program

Austin State Hospital

JOHN MIDDLETON, Director, Psychiatric Social Services
Austin State Hospital, Texas

IN AUGUST, 1958 the Austin State Hospital furloughed its 806th patient to a private nursing home. This represented an increase of over 300 since the last report in MENTAL HOSPITALS in March, 1957.

The program started as a small-scale attempt to reduce overcrowding of chronically ill seniles but has progressed to a very practical full-scale operation with placements now being made from admission wards and the outpatient clinic. The nursing homes have become increasingly more useful and are often utilized as "halfway houses" in the rehabilitation of geriatric patients. The over-all program gives adequate proof that the elderly patient can respond to proper treatment in a supervised home to the level of at least a social remission.

When a patient is admitted to the hospital, the social worker who secures his history also estimates for the relatives the likelihood of his becoming a candidate for nursing home care. She must be realistic in developing for the family an expectancy of symptomatic improvement, without promising a "cure," and must assure them that nursing home placement will be considered only upon the medical staff's recommendation after a thorough diagnosis and treatment.

Referrals Reviewed by Disposition Staff

Each hospital patient being considered for nursing home placement is reviewed by a disposition staff presided over by a consultant. This further guarantees the appropriateness of the referral. The typical patient referred may be described as: 60 years of age or older; suffering from a chronic brain syndrome with cerebral arteriosclerosis; only partially oriented as to time, place, or even person; having no grossly incapacitating cardiac or nephritic involvement; and with no other condition requiring bedside medical supervision. The typical patient requires only maintenance medicines which need not be given by professionals. Ambulation is not a necessary requirement, but tube feeding is prohibitive to placement.

Most often these patients have entered the hospital because of their acting-out behavior in the family home. The acceptable activity level of the patient differs from one nursing home to another, but the general level is one not requiring restraints or constant surveillance to protect the safety of self or others. The diagnosis or etiology itself is relatively unimportant.

A patient is referred for care in a nursing home in preference to his own home for two general reasons. Either his own home situation is not considered adequate to supply supervision, as may be necessary, on a twenty-four hour basis, or his medical needs are such that they cannot be met by relatives or community resources.

With the arrangements we make, the average cost of nursing home care has been $75 a month. Comparable private arrangements in this area average $100 a month for custodial services only; for nursing care by other than professional nurses, $150 a month; and for professional nursing care in a nursing home, $200 a month.

Conducting a continuously successful nursing home program has several hospital requisites: 1. A belief that the elderly patient is at least partially rehabilitable. 2. A well-trained social service staff fully cognizant of the total medical problems of the aged mentally ill patient. The social workers must be widely experienced and unusually resourceful to weld together all of the many agency, community, and hospital policies into a coordinated program. 3. A medical staff well oriented to the major aspects of the program and able to function appropriately at odd hours in event of serious illness or death in nursing homes. 4. Good hospital-community relations, and a clear concept of the program by all cooperating agencies. 5. Unrestricted, cooperative, interdepartmental communication—probably the principal ingredient of a successful program.

Selecting Nursing Homes

Licensing by the State Health Department remains the first criterion in selecting a privately owned nursing home. In addition, the home must satisfy the standards set by the hospital. The physical plant is inspected for safety, security, sanitation and housekeeping. Neighborhood environment is appraised as to location, fencing, traffic hazards, proximity of neighbors, noise level, etc. To assist in future placements a record is made of conveniences, such as proximity of bath and toilet facilities to sleeping area, accessibility of dining room, and arrangements for individual feeding. Employees of the home are interviewed for proper competency and responsibility.

Only after all of these qualifications have been pronounced satisfactory is an individual agreement made with the operator of the nursing home.

Contract Provisions

The agreement between the hospital representative (Social Service Supervisor) and the nursing home provides that:

A. *The Nursing Home Operator will:*

1. Assume responsibility for the furloughed patient;
2. Make reports to the hospital as requested on the condition and welfare of the patient;
3. Notify the hospital immediately in the event of serious physical illness or mental disturbance of the patient;
4. Arrange transportation for the patient's clinic appointments;
5. Notify the hospital Medical O.D. immediately in the event of the death of the patient;
6. Secure the services of a private physician or coroner in the event of death of the patient;
7. Notify patient's next-of-kin of the death and cooperate with burial arrangements.

B. *Austin State Hospital will:*

1. Accept the furloughed patient back as an inpatient at any time;
2. Send an ambulance to the nursing home when the patient's condition indicates;
3. Provide burial services in the hospital cemetery for indigent patients when necessary;
4. Aid in locating relatives in the event of an emergency;
5. Provide medical and dental care *pro re nata* on the recommendation or prescription of the hospital physician.

It is possible through the facilities of the outpatient psychiatry clinic to arrange nursing home placement without bringing the patient into the hospital. This method has several advantages. It causes less dislocation of the patient from his usual routine, avoids legal complications of competency, and does not sever any public assistance monies the patient may be receiving. In addition it tends to pacify guilt feelings the near relatives may have developed about institutionalization.

Often relatives who have already decided to place a member of the family in a nursing home will confer with the hospital for guidance about such homes. These people are aided by a social worker and, when indicated, are encouraged to bring the patient to the outpatient clinic so that an adequate medical and psychiatric examination can support the family decision.

Financial and Legal Arrangements

Financial considerations include: (a) the family's ability or willingness to contribute the full cost of nursing home care, or to supplement public assistance grants; (b) the patient's eligibility for public assistance; (c) his eligibility, or entitlement as a spouse, for Social Security, (d) possible VA Compensations and pensions, Railroad Retirement annuities or Civil Service Retirement; and (e) personal income or funds from any other source.

The patient's legal status determines how his funds may be handled. If he is incompetent he must have a guardian unless the resource is such that the hospital superintendent is custodian of the patient's funds. At present, there are two sources of such guardians—a member of the patient's family, or if the family is unavailable either by choice or because of distance, a volunteer or public service guardian.

Standardized legal forms for letters of application, affidavits for personal surety for the applicant, and orders appointing the guardian are processed for indigent patients by the supervising social worker for nursing home placement.

Furlough to Nursing Home

When all legal and financial arrangements have been made for the individual patient, the hospital social worker arranges with the appropriate nursing home to furlough the patient to its care. The attending physician reviews special medical, nursing or maintenance techniques together with recommended follow-up procedures for the social worker who interprets them to the nursing home personnel.

It has been found much more workable for these patients to be furloughed rather than discharged from the hospital. If the patient has a relapse or a new syndrome develops, it is much easier and safer to have him on furlough status and thereby subject to immediate rehospitalization. Discharge status necessitates additional court action before the patient can be readmitted to the hospital. Furloughing the patient reassures the nursing home operator that the hospital remains a continuous resource when the need arises.

Follow-Up

The hospital has no administrative supervision over the private nursing home, but enjoys advisory communication with the agencies which do have such jurisdiction. Because of excellent inter-agency relations, representatives of any of the agencies having jurisdiction over nursing homes can and do contact the supervising social worker when a patient's condition or a situation in a nursing home indicates hospital attention. This is termed "informal follow-up." The hospital retains the right to remove patients from any nursing home.

Routine follow-up is accomplished primarily through the nursing home operator's contact with the social worker. This is usually done through reports on the patient's changes of appetite, sleeping habits, activity patterns, or body eliminations, or on the nursing home operator's contact with the family.

Should the nursing home operator, one of the agency representatives or a member of the patient's family note a physical condition which should be revaluated, the operator notifies the Supervising Social Worker and the patient is scheduled into the hospital clinic services as an outpatient, or readmitted if required.

Returning Patient to Hospital

When a furloughed patient is to be returned to the hospital as an inpatient, the Supervising Social Worker makes all arrangements. These include authorizing the

patient's return through the hospital registrar, alerting the Nursing Service Division, when indicated, to send an ambulance with appropriate equipment, notifying the physician who will attend the patient upon arrival, notifying the appropriate hospital ward of the impending arrival, and preparing the appropriate admission forms. When the patient arrives at the hospital, a summary of all pertinent data obtained by the social worker is attached to his clinical chart and placed in the hands of the physician. This procedure, at times carried out in a matter of minutes, attests to the value of a well-organized, well-trained hospital staff. The accumulated data and any additional diagnostic or treatment recommendations serve as a basis upon which to determine the appropriateness of eventual re-furlough to a nursing home, or to a different nursing home if nursing needs of the patient should change. In this way, the returned patient is thoroughly revaluated, even though in some instances his stay in the hospital may be only two days.

Examining Team

Regular weekly visits to a nursing home by the Nursing Home Examining Team of the hospital assure that the patients are examined completely each six months. The Nursing Home Team, composed of a staff physician, a social worker, a registered nurse, and medical secretary, spends one-half day in a nursing home each week and makes as many trips to the same home as necessary to examine all patients regardless of previous clinic visits. The mental status, physical condition, and neurological status are revaluated. Referral forms, clinical records, vital information forms, etc., are brought up to date and complete records kept of the proceedings. A hospital medical technologist ordinarily re-visits the home the following morning to collect appropriate specimens. This re-examining has done much to enhance hospital-community relations and family acceptance of the program, as well as to give direct benefit and service to the patients. The preparation by the nursing home operator for the examining team is relatively simple. Only a private room, a table, adequate lighting, and a wash area are required. All other necessary equipment and supplies are taken to the nursing home by the hospital team.

Return to Family

The family is encouraged to visit the patient in the nursing home whenever feasible and upon the consent of the operator is permitted to take the patient out of the home for drives, meals, and visits during the day. Frequently the patient's adjustment becomes so stabilized and/or the family situation becomes so favorable that patients are re-furloughed to the care of the family. The financial resources developed by the hospital often contribute to improving the family situation where the family could not orginally keep the patient because of financial stress. In each instance the re-furlough to the family is evaluated on the basis of required custodial supervision, medical needs, and safety within the home. Last year, twelve patients recovered sufficiently to earn a full discharge. Thus the nursing home program has become also a half-way house program for rehabilitating the aged patient.

USES OF THE PAST

VI. *On Rediscovering*

IT IS EASILY taken for granted that current developments in psychiatric therapy are original because they are current; that they change the course of mental disorders because hospital statistics indicate higher rates of releases; and that they reflect favorably on our efforts because they indicate progress. Such a generation-centered point of view may well be regarded as natural. Nevertheless, the question arises whether we can profit from rediscovering aspects which were not only known but put to good use by men of preceding generations. One impressive example of "rediscovering" pertains to the present emphasis on milieu and relationship therapies for schizophrenics. The perplexing phenomenon about such rediscoveries is not the fact that something worthwhile is being revived and expanded but rather that valuable knowledge had been ignored or abandoned in the first place.

In 1912, Eugen Bleuler published his major work, "Dementia Praecox or the Group of the Schizophrenias." Far from promoting gloomy concepts with regard to prognosis and therapeutic potentialities, he stressed variability and variation in the courses of schizophrenia. Instead of seeing schizophrenic patients as social losses to be segregated in hospitals, he expressed a firm belief in the crucial advantages of early releases.

What of Bleuler's therapeutic results? It must be left to the reader to decide whether or not they exceed his expectations. Referring in 1912 to a group of 515 patients, admitted to the Burghoelzli Hospital between 1898-1905, he reported 60 per cent as separated from the hospital and "capable of earning a living;" 22 per cent as hospitalized and "completely incapable of social living;" and 18 per cent as "intermediary types." Bleuler added: "Naturally, these results get considerably worse with time. Yet few of those with a good remission have had to be returned to the hospital for permanent commitment because of a later exacerbation of the disease." These results must be challenging to those who ascribe their results to whatever specific treatment or program they believe in. It is quite apparent that Bleuler succeeded as a therapist because he concentrated on facilitating social adaptation. But his successes were not the accomplishments of a pragmatist. He was intensely aware of that aspect of the therapeutic process which we treasure as our most advanced understanding of the role of interpersonal relations in therapy: the priority of personality over method.

Thus, what is today heralded as a new, a milieu-oriented or interpersonal point of view, is actually an elaboration and expansion of traditional clinical experience. This realization, far from being historically embarrassing, can contribute to a better understanding of the scientific present as the continuation of the past.

F. A. FREYHAN, M.D.

Art for Therapy's Sake

By MARY HUNTOON, Art Therapist, Physical Medicine and Rehabilitation Service
Winter Veterans Administration Hospital, Topeka, Kansas

OUR ART CLINIC at Winter VA Hospital was established in April 1946. Dr. Karl Menninger was manager at the time and his oft-stated thesis that art is treatment for the mentally ill lent constant encouragement to the endeavor.

Today we conduct activities in 24 art mediums, which include painting in oil and water color; lithography; block printing; engraving on aluminum, copper and plastic; drafting; layout; sculpture and frame-making. To date, more than 1,000 patients have been assigned by their ward physicians for therapy in the Art Clinic.

While the Art Clinic staff gives instruction and guidance to the patients for whom this activity is prescribed, the emphasis is on art as a therapy and not as an occupation or hobby. Dexterity is no criterion for what may be done; the only prerequisites are the patient's interest and cooperation.

On leaving the hospital, patients who have had art lessons are encouraged to continue this interest as an avocation. Each is given a pamphlet explaining how art was used in the clinic and defining many art terms. We also give them a list of supplies needed and printed instructions for preparing a palette and caring for the materials and tools. Patients are urged to take up their art work immediately after discharge, for a delay makes it too hard to start again.

Exhibits Win Prizes

A sideline activity of the Art Clinic is garnering prizes at public art exhibitions. Each year since 1947, when we began entering works, our patients' entries have won awards at the Topeka Free Fair. To date nineteen prizes have been won at the fair, and these have been in all the mediums we enter: portraits and landscapes (in both oil and water color), engravings and sculpture. A patient's work is submitted only if his doctor signs a form saying its entry would be of therapeutic benefit to the patient. Each exhibitor signs and turns in his own entry slip and sometimes is responsible for taking his works to the fair.

One year we sent an exhibit of paintings to the Hobby Shop at City Hall; our entry won the Highly Superior Rating and nine patients won individual honors. In 1950 we were invited to send some art works to the International Congress of Psychiatry at Paris. The six pieces we sent included a 5'x5' canvas and a large sculpture.

Gallery and Loan Library Activated

Two other activities which grew out of the Art Clinic and of which we are quite proud are the Little Gallery and the museum project. The former is an area of the Art Clinic where we display current works; the paintings are numbered and the three best works each month are selected by ballot. The Little Gallery is an enjoyable mingling place for patients, their friends and relatives, and personnel.

The museum project was started 11 years ago when, at Dr. Karl's suggestion, 60 paintings produced in the Art Clinic were hung in the hospital's main corridor. The idea took hold and soon the walls of offices, dayrooms, wards and corridors were brightened with paintings. The paintings, which are numbered, are loaned like library books, with the borrowers responsible for them, and can be exchanged for different ones when desired. The patients themselves help select the ones they want for their wards and dayrooms.

The museum's collection now numbers over 3,900 paintings. This is many more than we can use in our new hospital—the old Winter VAH was a sprawling affair linked by numerous long corridors which accommodated a great many paintings. We have, therefore, set up an inter-hospital loan system to make the paintings available to other VA hospitals and affiliated institutions in Topeka.

23 went out...only 6 returned

If applied to an army patrol, those figures would be disastrous. But—referring to schizophrenic patients discharged from a mental institution after years of confinement—they are outstanding.

A recent follow-up study* of 67 institutionalized schizophrenics, many previously refractory to other therapy, showed these remarkable results *with Pacatal:*

23 (or 34 per cent) were able to leave the hospital. Only 6 had to return for further treatment.

Pacatal, unlike some earlier phenothiazine compounds, calms without sedating. It normalizes the thinking processes of the disturbed patient, yet leaves him alert and cooperative. On Pacatal, patients "became more accessible for psychotherapy and integrated more easily into the group."* Average dosage is 25 mg. t.i.d. or q.i.d. Literature available.

Supplied: 25 and 50 mg. tablets in bottles of 100 and 500. Also available in 2 cc. ampuls (25 mg./cc.) for parenteral use.

*Vorbusch, H.: Mepazine [Pacatal] in the Treatment of Psychiatric Disorders with One Year Follow-up, in press.

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WARNER
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PATIENT INTERACTION ON ADMISSION WARDS

By GRACE PENNINGTON SURBER, M.A., Psychologist

and G. DONALD NISWANDER, M.D.

Director of Psychiatric Education and Research

Arthur P. Noyes Institute for Neuropsychiatric Research

New Hampshire State Hospital, Concord

TODAY LARGE MENTAL HOSPITALS are focusing attention upon psychotherapy, ataractics, electroconvulsive therapy, insulin shock therapy and structured group activities as major tools of treatment for the newly admitted patient.

In stressing the importance of these procedures it is easy to lose sight of, and hence not fully utilize, the therapeutic potential which may accrue from day-in, day-out ward living and interaction among patients.

Routine observation by personnel is often insufficient to capture the full importance of patients' interpersonal relationships and what they mean to the individual patient in terms of hospital adjustment and improvement. Too often we miss the opportunity to learn at first-hand how the patient really feels about the new and strange environment of a mental hospital admission ward.

Former Patient Describes Reactions

The following excerpts taken from a letter of a former patient at our hospital concern her initial reactions to the admission ward. They seem to suggest that in her case considerable help came directly from fellow patients.

"Suppose I begin with my own reaction to admission, for I believe it is typical and characteristically introverted," she writes. "The depth of humiliation, guilt, and fear was beyond the telling. My only wish was to separate myself completely from the human race, and I did so emotionally for twenty-four hours. My self-devaluation was overpowering.

"My first conscious effort to relate to others took place the second day. On a torrid, humid afternoon seven patients, accompanied by a new student nurse and an attendant, journeyed through the long tunnel to the medical and surgical building." (The patients were being taken for routine X-rays.) "Two were old, frail, and senile. I recall my struggle to overcome my resistance when I became aware that one of the elderly patients required a supporting arm, and that my arm was elected. This was my initial, elementary step in freeing my mind. For what it was worth I was of value to a fellow patient and to an overburdened staff.

"That tiny incident was meaningful in helping me to relate to the group and become accepted by them. Although we were unable to continue our existence in the normal world because of our feeling of failure, conscious or otherwise, we could accept each other as a group, homogeneous in respect to being ill and facing problems of maladjustment outside.

"The next step came in individualizing patients and discovering that the patient load was a microcosm of the outside world. One of my fellow patients, alert to my cracking shell of aloofness, casually handed me a book, remarking that she had enjoyed it and thought I might share it. It was an expertly edited book of photography, and her offering of it served to introduce me to a person whose warm and intelligent personality served as a springboard to draw me out of my self-immersion further."

The patient continues with her feelings about interpatient relationships:

"These interchanges of mixed-up lives, similar feelings and common struggles afford a comfortable atmosphere where patients can relax with each other as they have been unable to do before. They enable some to obtain varying amounts of insight, unscientific though it may be, through observing others' activities, analyzing their reactions, and probing their motivations. . . .

"Patient relationships in the various groups play their part in re-creating security. . . .

"Psychiatry Mysterious and Threatening"

"I believe that an honest interest in helping the troubled is essential to becoming accepted as a helping person. Many of us, insecure and suspicious, conscious of our own inadequacies, place ourselves outside the reach of professional help because of the fear of giving ourselves away to ourselves as well as to the expert. Psychiatry is still, unfortunately, a mysterious and threatening thing. We can, however, talk to others like ourselves, and finding this not too painful, then go on from there. . . .

"Since I believe that a sense of concrete accomplishment can lead to something more abstract, I encouraged my friends to take part with the others in walks, sports, handicraft, music, bridge, or just 'rocking-chair togetherness,' according to the individual. . . .

"As I began to regain my own balance it seemed to help some patients to question my weaknesses and stresses and try to identify with me in my efforts to overcome them. . . ."

From these excerpts it would seem that this patient was greatly helped, and that she gained insight into her own illness through daily ward interaction with other patients.

Possibly the feeling of "all being in the same boat" is an essential factor in fostering a ward treatment milieu. Perhaps a better understanding of the multiple processes operating within the relatively unstructured society of admission wards, and a closer look at the part patient relationships and interactions play in recovery would provide us with other valuable clues to supplement existing treatment programs.

Rally Round the Ball Pole

RECREATIONAL and Activity Therapists may be interested in an outdoor game which came to the attention of MENTAL HOSPITALS this month. Since it requires only a twenty foot square playing area, and the cash outlay is small, it would appear to be within both the money and the space budgets of most hospitals. An added advantage is ease of installation.

With more and more open doors, and more and more ambulatory patients, the emphasis on activity as a part of therapy has grown to such an extent that administrators are hard put to find adequate outdoor play equipment to satisfy the demand. This game, with its built-in "aggression releaser," would seem to offer at least a partial solution to the problem. Not only does the actual playing of "tetherball" promise plenty of exercise, but the installation of the court can be a do-it-yourself project for those patients whose therapeutic program calls for less strenuous activity.

According to our informants, tetherball has been popular on the West Coast for over ten years, and is rapidly spreading across the country as a favorite back-yard pastime. The accompanying photographs and instructions were supplied by Voit Rubber Corp. of Los Angeles, manufacturers of the Official Tetherball.

Equipment

Official Voit Tetherball, Rope and 10′ pole. One end of the rope is attached to the top of the pole with a permanent, non-swiveling hook. Ball is attached to the other end to hang so the top of the ball is 3 to 5 feet from the ground. (It is recommended that the pole be permanently installed in cement or asphalt, or that a ground sleeve be permanently installed.)

Playing Area

A circle 20′ in diameter divided into two playing zones and two neutral zones. As the sketch shows, you may use the Clock Method of laying out the court. Draw a straight line between 2 and 8 o'clock and between 4 and 10 o'clock.

The Game

The game can be played with one individual against another or with two members on each side. Partners alternate turns at the ball as in table tennis, or hit by opportunity as in tennis. An unlimited number of players may be used in a team game. Each member of the team takes a turn at hitting the ball and then steps out of the circle to allow the next member of the team to hit. The game is played as a continuous relay until completion.

The object of the game is to wind the rope around the pole above the 5′ mark, or 7′ if adults are playing. (Note—it may be advisable to allow enough length at the top of the pole so the tether can be adjusted to accommodate all age groups.) The opponent attempts to wind the ball in the opposite direction. The ball is put into play by the first player who hits the ball around the pole. His opponent must allow ball to make an entire revolution before returning it in the other direction. Game continues with exchanges of ball until one player winds the ball completely around the pole, or a foul is committed. First server is drawn by lots. Winner of previous game serves.

Fouls

Any of the following fouls will cost a player the game.

1. Hitting the ball with any part of the body other than the hands or forearms.
2. Holding, throwing, or catching the ball during play.
3. Touching the pole or rope during the game.
4. Playing the ball while outside the court limits or while in the neutral zones.
5. Throwing the ball.

READERS' FORUM

On Knowing the Administrator *

It is not only possible to know the administrator as a human being—it is highly desirable. Too often administrators keep a distance by shielding their human side from superiors and subordinates alike. Large voids of information about the administrator as a human being force personnel to be cautious, for in this instance the administrator is essentially cautious too and this gets communicated to personnel. If the administrator assumes the "therapeutic" attitude regarding personnel, looking upon their ineffective operations not as evil but as their only way of solving what they are up against as people, and if he then applies the therapeutic rule of helping them over the obstacles besetting their paths to more effective operations, he will promote the emotional maturity and growth of his personnel, as well as securing a more dedicated staff and a professionally more efficient one. The administrator will find it more difficult to do these things if he conceals his human side because this will force his personnel to believe that he expects non-human (unknown) things from them.

P. G. ANGELOS, M.D.,
St. Elizabeths Hospital,
Washington, D. C.

* *See* MENTAL HOSPITALS, *Vol. 9, No. 9 November 1958, p. 6.*

Burnaby, B. C., Facilities Unite

Sorry to be late in writing to thank you for the article published in September issue of MENTAL HOSPITALS. The article has stirred a good deal of correspondence, particularly from people who have been associated with us in the past and have now moved on to other places.

Since the writing of the article, the two units have come under single management. We will be known henceforward as the Mental Health Centre, an outpatient psychiatric facility with an Adult Clinic and a Children's Clinic. My position is Director and Dr. Byrne resigned to go into private practice in June. If anyone wishes details about the architectural plans, the Provincial Department of Public Works, which was responsible for the design and construction of the building, would be glad to give technical information to anyone who is interested.

F. E. McNAIR, M.D.
Director, Mental Health Center,
Burnaby, B. C.

Privately Furnished Bedrooms?

During a recent visit to a state hospital in the Middle West, I saw in a chronic ward of regressed patients a room which had been furnished by the two patient occupants. Whereas the other bedrooms were clean and freshly painted, they were overcrowded with three beds, and were barren of pleasant non-essentials. The room furnished by the two patients had pink curtains and draperies covering the steel grate over the window. There were two beds of the "hollywood" type with headboards, pink chenille spreads, a modern dresser with a large mirror and two comfortable chairs. Since three beds would not fit, the room was less crowded than other patient bedrooms. The effect on the observer was startling.

It would make a lot of difference to our public hospitals if patients were permitted to furnish their own rooms—but I wonder whether or not this is a good idea? Personally I cannot decide. What do other people think?

LUCY D. OZARIN, M.D., Director
H.E.W. Regional Office, Kansas City, Mo.

FILM REVIEWS

THE INNER MAN STEPS OUT

Because the film reviewed below was received favorably when shown at the Institute in Kansas City, it has been added to the Mental Hospital Service Film Library. A supplementary booking form is now being mailed to all subscribers.

"The Inner Man Steps Out" tells the story of Jerry Allen, a supervisor who has trouble getting along with others and with himself. Despite his earnest intent to be "decent," his efforts backfire when he attempts to follow rules of good human relations. The audience sees him in actual problem situations with his family, with the men and women he supervises, and with his boss. Animation is used to explain how at least two "inner men" exist inside everyone—representing each person's need for security and for importance. With the help of a third "inner man," Jerry Allen realizes his own lack of understanding of the feelings and the inner needs of other people.

The picture does not show Jerry actually correcting his mistakes. Instead, the viewer is left in a reflective frame of mind so he will not only associate what he has seen on the screen with his own problems, but will be led to make changes in his own actions on the job—to *think* out and to *work* out solutions to any of his problems.

Some of the incidents covered are: 1) not listening to what other people have to say; 2) not recognizing individual differences in people; and 3) not respecting other people's feelings. Obviously, only the beginnings of the study of human relations problems can be covered in any half-hour film, but the intent here is to start people thinking and to spark further training activities.

Although designed primarily for supervisory management in industry, the film will have many uses in the mental hospital setting. The basic concepts of interpersonal relations will apply to doctors, charge nurses, charge aides, etc. Hospital administrators may therefore use it with all personnel—office or ward—who are in supervisory positions. It may also be helpful to aides and other employees who supervise worker-patients.

The film will have some value when properly introduced and used alone, but it will be far more effective if followed by a discussion. This is especially true because "The Inner Man Steps Out" is in no sense a "how-

to-do-it" film. Instead, it is designed to be an experience started on the screen, completed in the viewer and on the job. The film lives up to its stated purpose, acting and production are of professional caliber, and the message is leavened with just the right amount of humor. Hospital administrators who use this film are invited to send their comments on it to the Mental Hospital Service.

JACK NEHER

PSYCHIATRIC NEWSREEL

Psychiatric episodes aboard the atomic submarine Nautilus were non-existent, according to a Navy psychiatrist who appears in a new film for mental hospitals presented by Smith Kline & French Laboratories, Philadelphia.

Captain Jack L. Kinsey, the world's only submarine psychiatrist, who was aboard the Nautilus during its recent sub-Polar voyage is one of the key figures in Smith Kline & French's unique motion picture, "Psychiatric Newsreel."

In addition to scenes on submarine psychiatry, the 20-minute "Newsreel" covers current events in psychiatry such as the newly-constructed South Florida State Hospital. It also includes an exclusive interview with Dr. Daniel Blain, past A.P.A. Medical Director, and highlights from the world's First International Congress on Neuropsychopharmacology held recently in Rome. The "Newsreel" is available from Smith Kline & French representatives.

CONFERENCE REPORTS

NAMH ANNUAL MEETING

The increasing vigor of the National Association for Mental Health's programs and organization was evident during its annual meeting in Kansas City in mid-November, 1958.

Dr. Harvey J. Tompkins, first vice-president of NAMH and chairman of the association's professional advisory committee, opened the first formal session of the meeting with an address on new trends in the care of the mentally ill.

This was followed by a preliminary report on a project of the National Assembly on Mental Health Education, Pennsylvania Mental Health, Inc., and sponsored by NAMH and the A.P.A. Dr. John Perry Horlacher, Chairman of the Assembly, which was held in Ithaca, New York, last September, delivered the report.

The meeting reached its climax during the annual banquet at which former Governor Adlai E. Stevenson spoke on national mental health needs and announcement was made of a Rockefeller Brothers Foundation grant of $100,000 to NAMH's research program.

The grant, to be devoted to research projects, will be spread over four years. It will be administered by an NAMH research committee and by Dr. William Malamud, president-elect of the A.P.A. and director of the NAMH research program.

The research program was further strengthened by the announced intent of the national group to devote to research five percent of all funds raised by state and local associations. With over five million dollars having been raised by NAMH affiliates during the current year, the research allocation should reach at least $250,000 annually, exclusive of any specific grants or bequests made for research purposes.

With the research program under way, the association announced plans to develop a legislative program during the current year. Guiding the development of this program is Dr. Paul Lemkau, chairman of the recently organized NAMH legislative committee. Mrs. Virginia Beecher-Smith, formerly of the American National Red Cross, is NAMH's legislative representative in Washington. Development of the legislative program is expected to be gradual, beginning with an analysis of the major national and state legislative trends.

New Publications Announced

Further program development within the NAMH was evidenced by the publication, at annual meeting time, of two new manuals for affiliate societies. The first is a manual designed to assist local groups in developing realistic vocational rehabilitation programs for discharged patients. It was prepared by Morris Klapper, new assistant executive director of NAMH. The second publication is a revised edition of *Volunteer Participation in Psychiatric Hospital Services*, first copies of which were available at the annual meeting.

Of major organizational interest was the meeting of the Mental Health Association Staff Council held on the evening prior to the opening of the annual meeting. The council, composed of personnel employed by the national, state and local mental health associations, was formulated at the 1957 annual meeting "to provide for an interchange of knowledge and experience between the national office and state and local offices."

During the first year of its existence, the Staff Council has achieved a membership of approximately 500 persons, and held a workshop on legislation in Dearborn, Michigan. The workshop was supported by a grant from Smith Kline & French.

President of the Staff Council is Robert Barrie, executive director of the New York State Society for Mental Health. Mrs. Irene Malamud, former executive director of the Massachusetts Association for Mental Health, has been active in the development of the council and may serve as the group's unpaid executive secretary in the coming year.

Fund Raising Goals Clarified

The national association's fund raising goals were clarified for state and local executives attending a staff institute held just prior to the annual meeting. Robert N. Mazer, director of fund-raising, emphasized the need for: 1. Budgets to be formulated on program needs, with funds to be raised outside of Community Chest and United Fund organizations if current support from these sources is inadequate; 2. Increased support of the national association and of state associations by local groups; 3. Five percent of all funds raised to be allocated for research.

Representing the A.P.A. Central Office at the NAMH meeting were Dr. Mathew Ross, Medical Director, and Mrs. Lois Perry Jones, of the Joint Information Service which is supported equally by the A.P.A. and the NAMH.

Where Was Trigger?

Boys and girls from Glenwood (Iowa) State School were guests of Roy Rogers and Dale Evans for a two-hour performance at the Nebraska State Fair recently. A special invitation from Roy for the boys and girls to visit them after the show was negotiated by the school's superintendent. Above, the thrilled students and their counselors are shown with the "King of the Cowboys" and the "Queen of the West." Miss Evans is the author of the book, "Angel Unaware," the profits from which are contributed by her to the National Association for Retarded Children.

Patients Work as Library Assistants

"Above all, the institution of democratic principles for hospital patients will break down the barriers that set them apart from their fellow men," states Dr. Lucy Ozarin in "Freedom in the Mental Hospital."* The professional librarians at this hospital are striving to reach just such a goal in their work with patients assigned to the library.

As our particular business is conducted both with patients and with personnel, we prefer for library work patients who have demonstrated an ability to get along with all types of people, and those who have had some college or secondary education. (Ordinary janitorial service, for instance, requires little in the way of educational background, but library janitors frequently fill in at the desk, push book carts, process books, file cards, or perform other requested services.) In selecting patients for our staff, consultations with psychiatric aides from the wards are invaluable. Frequently the doctor is consulted for suggestions, and all assignments are approved by the doctor before they are made.

The patient with the longest tenure on the library staff was assigned from the geriatric building. (At the same time he was also sent to Occupational Therapy with the suggestion that he "might be up to weaving a rug!") During the seven years since that time, this patient has handled all phases of library work. At present he is in charge of the reading room at night and on Sundays, checks in and distributes newspapers to 26 dayrooms, writes for the hospital newspaper, and does many other library jobs.

The men working daily at the circulation desk bear the greatest amount of responsibility. Here they meet all patients, from locked wards as well as from privileged wards, and also all personnel. They handle all charging in and out of books and magazines, recommend reading material, solve brief reference problems, write letters for those unable to do so, and listen to numerous gripes and life stories.

Patients working in the library are often required to carry on their activities without the presence of a professional librarian. They are regarded with respect, appreciation, and possible envy by other patients. In addition, their services, their judgments, and their decisions are respected by the personnel who use the library. Compared to other patient-participation programs in our hospital, the library appears to offer the greatest freedom for the patients. As one "desk-man" remarked, "That's what I like about working here—some place to feel free." The responsibility, the respect, and the associations are indeed great morale builders for the ill men.

As the working group is small, the two professional librarians are able to take a primary interest in these patients, talking with them socially, teaching them library techniques, and listening to their complaints—always treating them as individuals with individual personalities as well as individual problems. Above all we try to promote recognition of their ability by the hospital staff. One doctor commented that this "Library Therapy" (his term) is a great factor in the patients' recovery.

BESS C. BURSINGER, Chief Librarian
VA Hospital, Tomah, Wisconsin

Volunteers Assist With Patient's Funeral

An unusual service provided by five church-sponsored volunteers at Willmar (Minn.) State Hospital recently, in assisting with the funeral of a patient, helped to console the bereaved family. The patient had been a member of the Sewing Club, a group of 20 patients from the disturbed and regressed wards. The volunteers, who are members of the Homebuilders Society of the Methodist Church, had known her very well for over a year through their work with the Club.

Since the family was unable to afford a private funeral for the patient, a hospital service was held. The five volunteers sang two selections at the service and afterwards served coffee to the relatives in an adjoining room. They told the relatives how much they had enjoyed working with the patient during the past year.

This gesture from the Homebuilders volunteers left the relatives with a warm feeling toward the hospital and its volunteer program. They expressed their appreciation by sending a small contribution to the volunteers to be used for missions in their church.

IRENE RYKKEN
Volunteer Coordinator

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* MENTAL HOSPITALS, *Vol. 4, No. 5, May 1953, p. 9.*

PATIENTS OR GUESTS?

A Hotelman's Point of View in a Mental Hospital

By FRANK WESTON, Public Relations Consultant
Butler Health Center, Providence, R. I.

WHEN THE TRUSTEES of Butler Health Center in Providence, R. I., engaged a business manager for the newly reopened institution which for 144 years had been known as Butler Hospital, they took a step which raised some professional eyebrows in the field of mental health institutional management.

They hired a hotel man!

"We found just the man we wanted," says Dr. Robert W. Hyde, Superintendent, "and the man we wanted was one who had never been connected with the management of a hospital. But he had to have had the experience and know-how which would qualify him to handle a substantial assignment. This assignment would include reconditioning and modernizing the physical plant, supervising the redecoration and refurnishing of a considerable portion of the available space, and managing the details of housekeeping, food service, groundskeeping, accounting and all the non-medical details of our operation.

"We considered ten well-qualified candidates for the job and hired the only one among them who had never had any hospital experience, but who *had* had hotel experience. Maybe it was an unorthodox step, but we are happy in our selection."

John Rock, III, came to Butler Health Center as Business Manager direct from the managership of Detroit's plush Town House. He is a graduate of the School of Business Administration, Division of Hotel and Institutional Management at Michigan State University, and joined the Statler organization in 1953 as Assistant Sales Manager of the Detroit Statler. Later that same year he took over the management of the Town House from his father. He joined the staff of the Butler Health Center on April 1, 1957.

"I didn't know it at the time," Rock says wryly, "but I am beginning to suspect that I am a sort of human guinea pig in a research project to find out whether a hotel background can be of value in this field.

"I didn't know anything about psychiatry, either, when I came here, but I am learning. One of Dr. Hyde's operating principles is that all members of the staff, in their attitudes and relationships with the patients, are important to their recovery and rehabilitation. Butler is an 'open door' hospital, and virtually all the patients have complete freedom of movement around the place. I talk to many of them every day. My office door is usually open and they wander in and out. In fact, some days I seem to talk to more mentally disturbed than normal people.

"I was talking business with a man in our cafeteria the other day when a paper he handed to me to read was snatched out of my hand by a young patient who said, 'Are you going to let me read it or should I tell you what it says?' He read it carefully while we both waited. Then he handed it back. I'd better use that on my next television program, don't you think?' he said. We both nodded gravely and he went away satisfied. My visitor and I resumed our conversation as though nothing unusual had happened.

Hotel Guests Often Difficult

"As a matter of fact," Rock added, "almost every hotel man has had a few guests from time to time with peculiarities of conduct which are not so very different from those I encounter among our patients at Butler Health Center. Actually, although I refer to them as 'patients,' I suppose I am really still thinking of them as 'guests,' and perhaps that is not such a bad idea. I have dealt with my share of alcoholics in hotels, soothed some very distressed folks and handled many people with acute behavior problems who were no less difficult to deal with than some who come to Butler Health Center for help. I'm no amateur psychiatrist, but in the hotel business you acquire some fairly handy common sense methods of dealing with people which seem to be equally applicable to patients in a mental hospital."

Job Offers Challenge

Rock says the principal reason he came to Butler Health Center lay in the challenge the job offered. On a tract of more than 100 acres immediately adjoining the best residential district in the city, were some 20 major buildings, many of them in disrepair, an antiquated central heating system, grounds that in 1957 were still littered with debris from the 1954 hurricane, a vast amount of brick in need of pointing, and virtually all exterior woodwork needing paint.

Yet all buildings were structurally sound, and in the two years during which the hospital had been closed, the community had been aroused to the need for its reactivation. A campaign to raise funds for its reopening and to cover operating deficits for three years had been substantially over-subscribed.

"We were in the same shape", says Rock, "as many a run-down hotel when new owners have taken over and are faced with the problem of re-attracting a high class clientele. To do this you have to have a high class operation. So your job is to repair,

remodel, redecorate and refurnish. You find two types of problems: things which have to be done at once and things you want to do eventually but can put off until later. So you put first things first and get to work.

"One of the jobs we tackled early at Butler was a complete revamping of the heating system, a job which was costly but which more than paid its way by providing an annual saving of some $25,000 in fuel costs.* Another was to install sprinklers in all patient areas, for obvious reasons an important and necessary precaution. These projects, together with essential repairs to exterior brick, outside painting and a general cleaning up of the grounds, were among the things which *had* to be done right away.

"It seemed logical to assume that, just as prospective guests would be more inclined to stay at a hotel which offered attractive and pleasant surroundings, patients would be less reluctant to pay the relatively high rates a private mental hospital must charge, if they were considered in exactly the same way as hotel guests. (Patients in public hospitals, by the way, are entitled to the same consideration.)

Color Used Freely

"Take the use of colors; we used color schemes at Butler in just the same way we would if we were designing hotel interiors. There is no good reason why a mental hospital interior should be drab and colorless. Patients appreciate surroundings and a variety of colors just as hotel guests do.

"We have evidence, too, that patients appreciate good furniture. We have two wards of new furniture and we have not had one burn or any other damage to this furniture, while almost daily in the wards where we still have old furniture, something is destroyed or broken.

"In the new cafeteria, where 90 percent of our patients as well as the nurses and other members of the staff take their meals, this same appreciation is evident. I think our patients take a lot of pride in the cafeteria** and the feeling that they are not being isolated from the society of others. We require everyone to return his dirty dishes to the dishwashing station before leaving the cafeteria, and except for a few who are unable to do so, everyone faithfully complies with this rule. As a matter of fact, members of the staff are more likely to disregard it than are patients."

Rock feels, too, that it is worthwhile to give time and thought to the arrangement of furniture. In the patient lounges, furniture is arranged in "conversational groups," just as it would be in a well laid out hotel lobby, with card tables and game tables for the convenience and use of the patients. The institutional "day room look" has been banished. There are racks of drawers and the games and cards and other materials can be put away neatly when they are not being used.

All the patient lounges have hi fi and television, and the activities in these rooms are much the same as they would be in a resort hotel. Some patients will want to read or play cards; others will prefer to listen to music or watch television; all will not want to do the same thing at the same time, so the furniture is laid out to give patients as much choice as possible.

However devoted Rock has been to following hotel practices, he has had to make some concessions to certain fundamental differences between average hotel guests and mental hospital patients. "But not so many as you would think," he says.

"In our more disturbed wards and in the sitting rooms, we think it is wise to have materials that will not burn. Our new drapes in the patients' rooms are of Fiberglas, which will not burn and is extremely good-looking. Sponge rubber makes very comfortable upholstery for chairs, but it is highly flammable. So we use polyethylene slip covers and have plenty of extra sets which can be zipped off and replaced quickly when they need cleaning (See page 38).

"In our new geriatrics wing we are carpeting the halls, but we have replaced the wood floors in the rooms with asphalt tile which can be cleaned thoroughly and easily. A wood floor that is constantly soiled will give off a stench you cannot get rid of, so tile is indicated for these rooms, but presents the problem of accidents. Elderly people, not too steady on their feet, are apt to slip on a polished tile floor with dire results. So we use a non-skid floor wax produced by West Chemical Company which polishes to mirror brightness and seals the floor, as well. I defy anyone to slip on it. So our particular problem here is solved. And this is something the hotel industry could well follow. What we learn in one field can often be applied to another."

Hospital Employees Considerate

Rock does not think there is any essential difference between the attitude of hotel employees toward guests and hospital employees toward patients. "To be a good hotel employee," he says, "you have to like people and be considerate of their comfort, and there is no difference in the hospital employee's feelings toward patients. If anything, the average hospital employee, being more aware of the special needs of mental patients, is inclined to be more considerate than the average hotel employee.

"Most of our employees will go out of their way to do the many extra little things for patients' comfort that good employees of hotels do for guests. If they are unwilling to contribute to these extras, then they are not good hospital people and they would not be good hotel people either. Perhaps an elderly patient coming into the cafeteria may be confused about getting into the line and just sit down at a table. I've seen the counter girl make up a plate for such a person and take it over to his table and then, if he forgets to take off his dishes, clean up the table as well. She isn't required to do this, but a hospital or hotel employee who is unwilling to do anything not specified in his job description isn't worth his salt. The principal difference is that in a hotel he would probably earn a tip; in a hospital, he does not expect any gratuity."

Employee grievances in a hospital are much the same as in a hotel, Rock finds, with some few differences. Mental patients sometimes ruin a nurse's stockings or rip a male attendant's shirt. These articles are all replaced, of course, and the patient pays the bills, as he does for all types of property destruction for which he is responsible. Rock is philosophical about damage. "I'd rather have a patient

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* *See* MENTAL HOSPITALS, *Vol. 9, No. 3, March 1958, p. 26*

** *Ibid Vol. 9, No. 8, October 1958, p. 30*

break a table than a nurse's arm," he says reasonably, "and I'm sure she would, too. Of course, the breakage is higher in a mental hospital than in a hotel, but don't be too quick to minimize the latter. Hotel guests can be pretty rough on the furniture, too, as any hotel manager doing convention business can testify. And it is often pretty difficult to find the right guest to bill for the damages, so in most cases it goes into the cost of doing business.

"One great problem we have in the hotel field that we do not have in the hospital is pilferage. Silverware, napkins, towels and other light and easily portable items d i s a p p e a r in large quantities every year from hotels, and some larger items, too, like blankets, bedspreads and pictures. In fact, I can recall a hotel man telling me about a guest who successfully negotiated the disappearance of an armchair before he checked out of a midwest hotel! We don't have that problem in the hospital."

Personal Satisfaction Greater

Rock believes he gets more personal satisfaction out of his present job than he did in the hotel business. "Oh, you like it a lot when a hotel guest tells you he enjoyed his stay; that the food was good and the rooms comfortable and that he will be back again soon. And you glow a little when you get a letter that compliments you on your standards of service. But none of that compares with the satisfaction you get when you see a patient check out of the hospital ready to go back again into the mainstream of life, his mental disturbance overcome, his fears and his panic forgotten.

"Not long ago, a young man who had been with us for several months stopped in my office as he was leaving. 'Goodby, Mr. Rock,' he said. 'It's been swell being here. I'm going back to college. I feel fine. Just fine.' I couldn't help but think how sick he had been when he came in and how much had gone into getting him well enough to go out again. It was a combination of everything we offered—therapy, medication and care, the attitudes of people with whom he had come in contact. I feel that I have a part in all this, and that is where the sense of satisfaction comes in. There is nothing exactly like it—anywhere."

A PREVENTION PROGRAM PAYS OFF

By JOHN M. FAHEY, Safety Officer
Veterans Administration Hospital, Brockton, Mass.

A CONTINUING PROGRAM of safety and fire prevention training under the direct supervision of the safety officer has paid dividends to the Veterans Administration Hospital in Brockton, Mass., in a minimum of lost time from disabling injuries.

The subjects covered are accident reporting and prevention, classes of fires, and the use of fire extinguishers and hose lines on oil, wood, paper, and rubbish fires. A written examination is conducted after each class, and employees failing to pass are required to attend additional classes. Films, safety graphs, posters, etc., are used constantly.

Our hospital is located on the outskirts of the city of Brockton, and we are protected by the municipal fire department. In our safety and fire prevention program, we have provided some protection for ourselves. We have procured a six-foot steel trailer and equipped it with firefighting tools, nozzle, double-jacketed hose, fire extinguishers, etc. This trailer has been used extensively for drills and training periods.

Interior of fire apparatus closet: standpipe and unused hose rack are at center; below them is new latticed shelf for folded hose.

Emergency Squad Organized

We have recently organized an emergency squad that responds to fire drills and other emergencies. It is being thoroughly trained in the use of fire extinguishers and other equipment, evacuation, etc. The plan is simple and the response on all drills and actual emergencies has been rapid and successful.

The telephone operator during the day and the registrar's assistant during the night put the plan into operation. When a telephone call or fire alarm signal is received on the tape register at the telephone switchboard, the person operating the switchboard immediately inserts six telephone jacks connecting six nurses' stations and holds the six bell keys down, giving the telephone bell a continuous ring. The six stations permanently selected are occupied 24 hours daily and one male nursing assistant is assigned this duty on each station. Fire is never mentioned. The message, "emergency," and the location of the danger—ward, building, or other area—is delivered and received in seconds, and trained personnel start for the affected area automatically.

Following this, the operator puts in motion the second step. This includes the calling of trained personnel from the engineering division with the fire trailer and additional equipment.

We have stopped using the steam whistle and siren. The personnel concerned are now alerted by the visual call system. A soft-ringing chime has been connected to our visual call system and the ringing of the chime and the flashing of zero followed by a building code number indicate a fire. This eliminates work stoppage and confusion throughout the hospital.

The third step consists of notifying the manager, assistant manager, director of professional services, and the engineer officer; and sending in the alarm for the Brockton Fire Department if necessary.

New Safety Measures Developed

Some changes which have proven beneficial as a result of our program are:

a. The installation of latticed wood shelves in the fire apparatus closets. This hospital was equipped with Underwriters' approved semi-automatic hose racks for 1½ inch linen hose which were installed on the inner side wall recessed 14 inches from the door. During fire drills, the rack would swing against the door casing and the hose and pins would jam in the rack, making the delivery of water impossible. As structural changes would have been necessary to relocate the hose racks to overcome this, the engineering division built latticed shelves (from reclaimed lumber at a small cost) which provide fully automatic action for the linen hose. The pressure at the standpipe pushing the linen hose from the shelf now makes it a simple operation for one person to pull the nozzle and hose from the opposite end. This shelf also simplifies the refolding of the hose, which is done monthly to prevent the folds from cracking.

b. We have eliminated the need for storing sulfuric acid for recharging soda and acid fire extinguishers by converting them to the CO_2 cartridge type with a reasonably priced conversion kit.

c. In critical areas, we have provided extinguisher carts made from scrap metal and the wheels of broken or discarded carts. These attractively painted carts with safety signs and slogans can be wheeled easily by female employees. The heavy 15 pound CO_2 extinguisher does not need to be lifted from the cart and the extinguishing gas can be directed to a burning surface by squeezing the handle or opening a valve.

Developing Procedural Manuals For Institutions

By GERALD GARTENBERG, Director
Office of Planning & Procedures, N.Y. Department of Mental Hygiene, Albany.

ONE OF THE specific functions of the Office of Planning and Procedures, organized in the late summer of 1954, is "to prepare and maintain up-to-date manuals of procedures for administrative, business office, and clerical operations."

Its first assignment was to develop a procedure manual for the business offices of the 27 different institutions of the New York State Department of Mental Hygiene. This was followed later by a Reception Service Manual (now being expanded to include chronic and continued treatment services), a manual covering the program plan of after-care clinics in New York City, a Personnel Policy and Procedure Manual, a Laundry Manual, and a manual for the finance office of the Department of Mental Hygiene. Other manuals for nursing services, occupational therapy and food services, have been developed and issued by service heads and consultants.

Owing to differences in subject matter and the clientele served, the development, style and format vary for each manual, although each one developed by the Planning Office is designed to achieve similar goals. The basic objectives of all these manuals are:

1. To provide a structure for the systematic maintenance of all current written statements of program, policy, procedure and forms.
2. To assure adequate clearance and distribution of such statements.
3. To establish minimum standards of performance for basic operations.
4. To assign functions and activities to specific positions or organizational units, thus clearly delineating areas of responsibility.
5. To provide a basis for evaluating activities against written standards, policies and procedures.

The development of the Institution Business Office Manual is described in detail here and the Laundry Manual and Reception Services Manual are covered briefly.

Institution Business Office Manual

The plan for developing this manual called for the determination of the organization and functions of the business office and the clientele to be served. Rather than visiting all 27 institutions, we decided to visit a representative number of the business offices to obtain the necessary information. These were selected in consultation with the Business Assistant to the Commissioner.

At the same time, the Office of Planning and Procedures was responsible for developing written procedures and training material and also installing a new merchandise accounting system for food, clothing and household items. This new system had been proposed and developed by the administrative management unit of the Division of the Budget prior to the establishment of the Planning Office. It was decided to dovetail these two projects.

Field trips revealed that the organization of the business office was almost the same in all institutions, and that there was little variation in the functions assigned to the respective organizational units. Each business office consists of the following units: administration (business officer and his assistant); voucher unit; merchandise unit; payroll unit; cashier unit; and a ledger posting unit, which handles patients' cash.

It was decided to include in the manual clerical procedures of the storekeeper's unit, and the bookkeeping procedures for the community store bookkeeper in order to tie in the flow of work.

Since the manual would be used by clerical workers as well as the business officer, assistant business officer and unit supervisors, an outline style using the imperative mood was used. Each activity was started on a separate page. Where applicable, the background of or basis for the activity was given briefly at the top of the page. This was followed by three major divisions: A) Material Received, B) Operations and C) Disposition.

The unit supervisors in the finance section of the office of business administration in the Central Office were interviewed to determine what information and reports must be submitted by the hospitals and schools, the format in which they are to be submitted and the timing of such reports.

A draft was prepared of all the functions of the business office, and each function was assigned to a specific organizational unit. The business officer, assistant business officer and unit supervisors were interviewed at the selected hospitals and schools. Finally, the employees actually doing the work were observed and questioned.

The records and forms used in each of the organizational units were analyzed to determine the purpose served and results obtained. After information had been secured from several hospitals and schools, the first draft of the procedures for a unit was

prepared and submitted for comment to a committee of business officers.

As the new merchandise accounting procedure was installed at each institution, certain activities were reviewed and various personnel interviewed. Thus each institution participated, directly or indirectly, in the development of the manual.

After the procedures for all units had been cleared with the committee of business officers, the manual was referred to the Field Audit Section in the State Comptroller's office. The Comptroller has responsibility for all accounting procedures in the State of New York. A series of meetings was held with the Comptroller's representatives who reviewed and approved each item in the manual.

The next clearance involved meeting with the Business Assistant to the Commissioner. All comments and suggestions made by business officers and the Comptroller's representatives were given full consideration before a decision was made.

For final clearance the latest draft of the manual was sent to all hospital directors and business officers. The latter group was requested to review and discuss the manual and its provisions at a business officers' conference. After the conference, the manual was reproduced by offset press, placed in loose-leaf binders and eight copies were sent to each institution.

After the manual had been released two major sections were added. These additional sections covered the responsibilities of the business officer and his assistant. Since these two persons act in executive capacities and their methods are a matter of judgment, the items were written in narrative style and covered only broad duty statements.

The manual contains almost 200 items and to date there have been about 30 item changes a year. Most changes occurred in the payroll unit.

The objectives set for the manual were reached after it had been in effect for about one year. In addition, other benefits have accrued. In developing the procedural details, the simplest procedures were selected and some were streamlined by the Planning Office personnel. The manual made available to all business offices the various ideas developed and used in individual institutions. Another benefit was the elimination of some records and reports maintained by many of the institutions, since only the information specified in the manual was called for.

The manual is also used as a guide by the Field Audit Section of the Comptroller's office in making audits. Each auditor has a copy of the manual. The auditors do not request data not specified in the manual. Any information not in the manual that the Comptroller's representatives feel is necessary is channeled to the head of the Field Audit Section in Albany who discusses the matter with the Business Assistant to the Commissioner. If, as a result of this discussion, the additional work is deemed advisable, uniform instructions in the form of new or revised manual pages are issued to all business officers.

Reception Service Manual

The development of this manual called for visits to selected hospitals, development of a rough outline of the manual and the establishment of an ad hoc committee.

This committee was composed of an assistant director, a supervising psychiatrist, chief supervising nurse, head nurse, supervising social worker, staff attendant, and senior medical record clerk.

In addition the following Central Office personnel were on the committee: director of social services, assistant director of nursing services, director of statistical services and the director of planning.

The committee met a number of times, reviewed written material and suggested revisions, additions and deletions. After approval by the committee, the manual was referred to the Committee on Medical Care and Administration, which is composed of hospital and school directors, for review. The manual was then referred to the quarterly conference of institution directors where it received final approval.

The Manual of Reception Service Procedures does not contain specific detailed instructions as does the Business Office Manual. It lists all the clerical administrative functions of the reception service and assigns responsibilities to specific positions. The steps for each activity are listed in outline form. In addition to the activities of medical and clerical personnel, the manual covers the activities of the ancillary services. Copies of the manual were distributed to each interested person.

The manual has simplified reception service procedures and eliminated 19 forms. It is now being expanded to include the continued treatment services. Its title will be changed to Manual of Medical Administrative Procedures.

Institution Laundry Manual

This manual was developed jointly by the Department Laundry Consultant and the Office of Planning and Procedures. After an examiner from this office had visited various institution laundries and interviewed the laundry managers to become acquainted with laundry operations, flow of work and terminology, the Laundry Consultant was requested to prepare a list of topics that should be in a laundry manual. To these were added items concerning organization and staffing of the laundry, duty statements and a section on laundry control. Laundry manuals prepared by federal agencies and by vendors of laundry supplies were studied, particularly technical material on washing policies and procedures, to ensure that all laundry activities were covered in our manual. The entire manual is written in narrative style; detailed steps cannot be shown because the laundry facilities vary among institutions.

Upon completion, the Laundry Manual was cleared first with a committee of laundry managers, and later with the directors and laundry managers of each institution, and finally released late last summer.

Distribution and Use of Manuals

Because of the size of the Department of Mental Hygiene, the demand for all manuals has exceeded the carefully planned distribution lists.

The manuals that have been issued are generally serving the purposes for which they were designed. Each declares in its introduction, or in the letter of transmittal, that its instructions and standards are guides, intended to make clear the function or process covered. It notes that because of variations in size, layout, personnel and other factors, some deviations may be in order, provided they meet the objectives of the procedures.

THE RECEPTIONIST—AMBASSADOR OF GOOD WILL

CHRISTINE BAKER, Receptionist
Eastern State Hospital
Vinita, Oklahoma

THE RECEPTIONIST in a mental hospital serves as the front for the whole administration, so it is from her that the public gains its first—and sometimes its most lasting—impression of the institution. Yet, in some hospitals (fortunately, not in mine) we are expected to be ambassadors of good will without being given the information we need to do our job well.

The patient and his family coming to the hospital for the first time may be apprehensive and anxious. A properly trained receptionist with an appropriate personality can do much to alleviate this disquietude. On the other hand, an idly chosen and poorly indoctrinated receptionist can increase and intensify the fears connected with hospitalization. Even her voice can have a calming or an upsetting influence.

It takes tact and diplomacy to deal with people, particularly sick people and those who accompany them, but these attributes are not enough in themselves to make a good receptionist in a mental hospital. We must in addition have knowledge—a thorough knowledge of the departments and functions of the facility we serve and, even more important, a knowledge and understanding of what the administration is trying to accomplish. When new techniques and methods are introduced to improve the milieu of the institution, we have to know why they have been adopted and what their purpose is before we can interpret them correctly to visitors and other members of the public with whom we come in contact.

In many instances the receptionist also serves as the switchboard operator, thus greatly increasing her contacts with other people inside as well as outside the hospital. She is the connecting link between all of the people who work in the institution and those who come to it for treatment, for business purposes, or merely to visit.

The past few years with their heightened interest in improving the care and treatment of mental patients have lightened the load of receptionists even while increasing our responsibilities. We have more appointments to make for other disciplines as well as for physicians; but by the same token we have more of these professional people to relieve us of the delicate task of dealing with overwrought and anxious relatives of mentally ill persons. We have many more requests for information as the public grows more enlightened; but we have been provided with good, well-written books and pamphlets to assist us with our answers. We have more and different kinds of treatment areas to direct people to, but thank goodness many hospitals, like mine, have adopt-

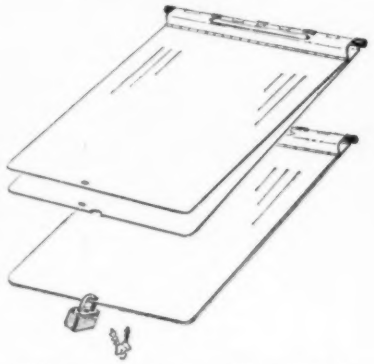
ed a numbering or lettering system for their buildings so we no longer have to say "Hydro," "Infirmary," "Acute Ward," etc. In addition, quite a few large institutions have discovered the value of small, hand-out maps to illustrate our verbal directions.

In some hospitals the receptionist is responsible for the master file which shows the location of each patient in the building, his name, county and town, date of admission, permissible visitors and their names and addresses, and the privileges he is able to enjoy. A growing awareness on the part of staff of the value of records as an adjunct to therapy has placed increased emphasis on the maintaining of this file. It is tedious and time consuming to keep it current and accurate, but this same growing awareness makes the staff much more willing to cooperate in providing the necessary information.

Finally, the recent improvements in the care and treatment of the mentally ill have contributed one great boon to the receptionist in the mental hospital. It is true that our duties and responsibilities have increased because more people are aware of the value of psychiatric treatment. It is true that we see more sick people coming into the hospital. But now we also get to see more people *going out* of the hospital and into the community to take up their lives again. And this is what makes our jobs truly rewarding and worthwhile.

Chart Lock Permits Transportation by Patients

The VA Hospital in Houston, Texas, is using a practical chart-locking device which allows unescorted patients to carry their own medical records to save staff time.



The drawing above illustrates how the lock works. By drilling a hole through a regular metal or wooden chart holder and inserting a small padlock, the enclosed records are made inaccessible to the patient as he carries them with him from one area of the hospital to another.

To further simplify the procedure, each ward or department has a key that will open the lock.

Exact specifications for preparing chart holders for locks will depend, of course, upon size and type of equipment used. However, there are certain general recommendations which will apply. The holes for the padlock must be positioned so that the lock when in place, will clear the bottoms of the pages enclosed. A clearance tolerance of ¼" from the end of the chart holder is usually sufficient.

The hole should be drilled about ⅛" larger in diameter than the thickness of the lock ring to facilitate locking and still insure a firm fit.

Finally, enough keys should be made so that each department can have at least one.

Two other VA hospitals, in Muskogee, Oklahoma, and Kerrville, Texas, have also employed this method successfully.

TILLMAN S. JOHNSON
Registrar

Social Security Benefits Mentally Retarded

A big project underway at Pacific State Hospital, Pomona, California, an institution for the mentally retarded, is the screening of all patients' files to determine eligibility for Social Security benefits. Any indication that a patient might be eligible for benefits is immediately followed up by letters to relatives, requesting information for filing formal applications with the local Social Security office.

In addition to Social Security matters, the accounting department handles all trust activities for its patients. Claims are filed with the Veterans Administration and the Railroad Retirement Board on behalf of patients. As a result of this activity over 40 patients are now receiving direct monthly benefits from these sources.

While some of the various benefits are paid to the families of the patients, most are paid to the hospital for deposit to the patients' accounts. Together with funds received from relatives the accounting department maintains more than 1200 individual accounts with total deposits in excess of $95,000. These funds are used for the welfare of the patient to purchase extra clothing, toilet articles, candy, ice cream, dry cleaning, and other articles or services not normally provided by the state.

E. G. ALLEN
Accounting Officer

Plastic Materials and Fire Hazards (SEE PAGE 32)

The earliest plastics were made of nitrocellulose (or bakelite) and, being similar chemically to nitroglycerin, were highly flammable. During the past 20 years, as a result of the progress made in knowledge of the polymerization of organic chemical radicals, the various chemical companies have created a vast number of different plastic materials. These new plastics, produced by polymerization are "elastic" in nature, and are generally known as Elastomers. The polyethylenes, polyurethanes, vinyls, etc., are of this order, and it is possible to control their chemical linkage to produce almost any desired degree of hardness, toughness or elasticity. Although these new plastics do not burn with the same ferocity as the early nitrocellulose compounds, they must, however, still be regarded as less than fireproof. They are usually described as: "flame resistant," "flame retardant," "will not support combustion," etc., which indicates that although they might not burst into flame they do react unfavorably to high temperatures. They may, for example, melt under the flame of a match but not burn. Their greatest danger is in the production of noxious fumes when exposed to very high temperatures. Although the art of plastic manufacture has not yet solved this problem entirely, progress is being made fairly rapidly. It is recommended that caution be used in selecting plastic materials where fire protection is desired. Incidentally, Fiberglas is made of glass fibers and is, therefore, completely fireproof.

ARCHITECTURAL STUDY PROJECT

ARCHITECTURAL Feature Of The Month

A Triple Purpose Activities Building

Faribault State School, Minn.

By LOUIS R. LUNDGREN, Architect
Haarstick Lundgren and Associates, Inc.
Saint Paul, Minnesota and San Francisco, California

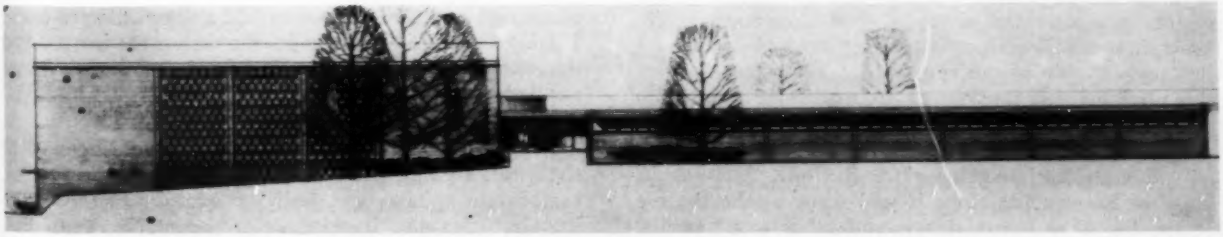
A NEW TYPE OF BUILDING nearing completion at the Faribault State School and Hospital is certain to bring a bright change in the social and educational opportunities of the institution's 3200 mentally retarded patients. The new Activities Building provides a central facility not previously available, combining recreation and education facilities for patients and dining facilities for employees. This "campus union" type of building will meet a need long felt by the institution's administrators.

The Activities Building was one of the most challenging buildings among several designed by our firm as part of a multi-million dollar construction program begun at Faribault in 1956.* As directed by the client, the building was to combine "mass indoor recreation and assembly facilities, educational classrooms, therapeutic craft facilities, and food service and dining facilities for staff and employees." In short, the building would divide roughly into three units—educational, recreational and dining. Our design objectives were to provide functional arrangements of space, a healthful physical environment and a stimulating visual environment. While many of the design problems were quite similar to those encountered in planning an ordinary school plant, our research indicated that most of them would require rather different solutions.

As a first step in functional planning, careful consideration was given to the location of the building in relation to the campus and to the placement of various facilities within the building. Because it was to be a union type of building for patients and employees, a central location seemed mandatory. Orientation of the building on the east-west axis of the site was somewhat dictated by the fact that boys' dormitories are situated at the south end of the campus and girls' dormitories at the north. It was necessary to have entrances which allow access to the building from these two directions. These entrances—ramp-type for wheel chair patients—were placed at the ends of the lobby, which connects the auditorium-gymnasium to the education unit. This allows a better control of traffic into and out of the building. Because the site slopes from east to west, the building is a split level, with the auditorium-gymnasium and the staff dining area in a two-story unit at the west end and the education facilities in a low one-story unit surrounding a court at the east end.

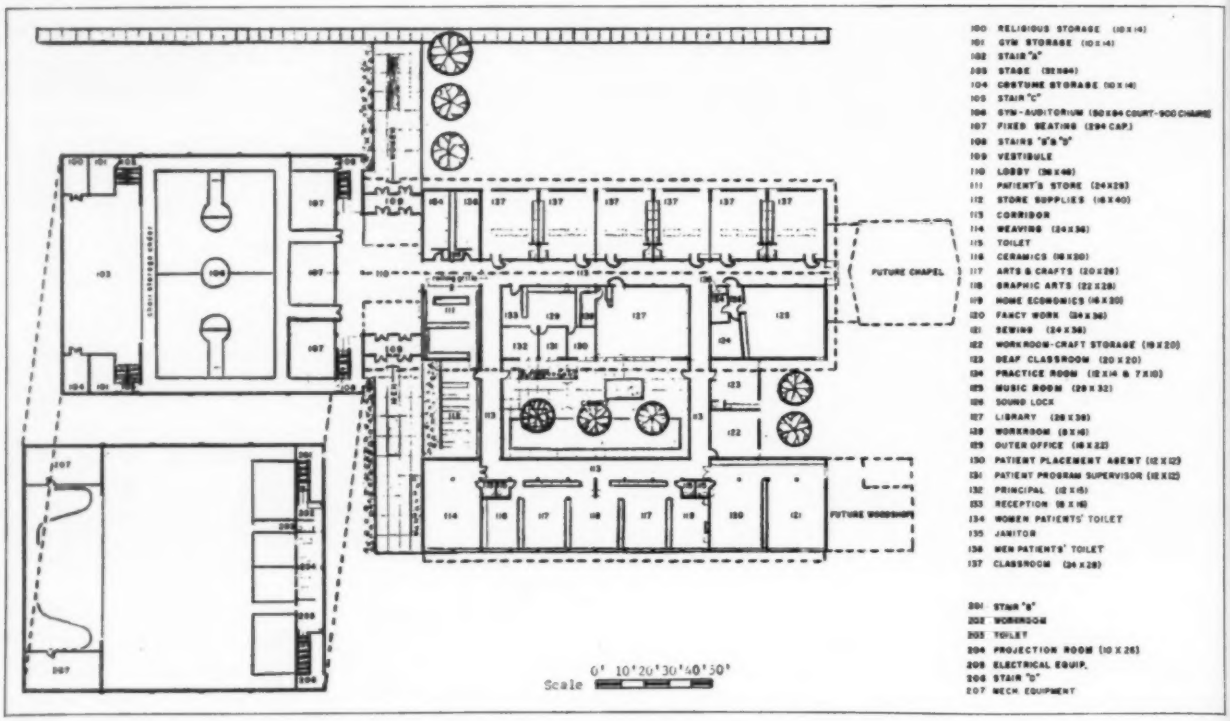
Educational Facilities

The greatest challenge in designing the building came in meeting the need for flexibility. This unit is, in



Brick retaining walls, aluminum awning windows and careful landscaping enhance the exterior appearance of the building.

* See MENTAL HOSPITALS, *Vol. 8, No. 9, November, 1957, p. 29.*



essence, a small school building designed for the education of mentally deficient children and adults with a mental age of six years. The range in physical age is great, with no correlation to the mental age. Consequently, the height of equipment and facilities was planned to allow adaptation. Chalkboards and tack boards, for example, are mounted on rails, to allow them to be raised and lowered to fit the students using them.

Because it is important that these patients have an opportunity to work with their hands, extensive arts and crafts facilities are included. It is not easy to predict which of the various crafts will be most popular, and so another major provision for flexibility was incorporated into the building. The partitions between arts and crafts rooms are demountable, movable cabinets that can be shifted to alter the sizes of various craft rooms as the needs for space change.

The over-all function of the education unit is otherwise similar to most school buildings being designed today, and the facilities provided are similar also. An office suite is located just off the lobby, with space for waiting room, clerical office and offices for the school principal, patient program supervisor and patient placement agent. The library and music room are located on the same corridor as the general classrooms, while the craft rooms, where activities are more noisy, are on the opposite side of the courtyard. This central court adds a stimulating outdoor environment.

Recreational Facilities

In the auditorium-gymnasium flexibility was again of prime importance, since it will serve as the theater for movies, stage shows, dances and other social events, as well as for sports activities. Church services also will be conducted here, with three basic church services weekly, and so particular emphasis was placed on design of the organ sound system in the auditorium.

Physically allied with the education wing, but functionally attached to the gym-auditorium lobby, is the canteen where patients can buy tobacco, toys, confections and personal supplies, and where articles made by the patients will be sold to visitors. Toilets for both patients and visitors are located across the corridor from the canteen and adjoining the lobby.

Dining Facilities

On the ground floor below the auditorium, provided with ground-level entrances, are the dining facilities, lounge and canteen for employees.

The dining and lounge facilities are in the core of this ground floor space, segregated from the locker and shower rooms and other patient recreation facilities on three sides of the perimeter.

Materials

The materials for institutional buildings are designed to be durable, easily cleaned and requiring low maintenance. While these qualities are highly desirable from a practical standpoint, few of them convey the feeling of warmth and intimacy we wished this building to have. Having faced this problem in our design of two 100-bed dormitories for the Faribault school and hospital, we applied the same principle of using color, texture and proportion to ease the usual institutional effect.

Landscaping at the perimeter of the building and in the interior court, plus careful placement of glass areas, combine to enhance not only the exterior of the building, but also the interior environment, by providing attractive views at many places throughout the building.

THE PSYCHIATRIC MODULE

By CHARLES E. GOSHEN, M.D.

A.P.A. Architectural Study Project, Washington, D. C.

ARCHITECTS make wide use of the term "module" to indicate the basic reference dimension of any particular design. In its literal sense, the module is the "typical" dimension, the basic unit of measurement with which all other measurements of a building are compared. Standardization, mass production, replacement and maintenance are greatly facilitated by the adoption of common modules.

In addition, the term "module" is sometimes used in a broader, more philosophical or theoretical sense, to refer to any base of reference. Thus, the "design module" for a typical general hospital is "the bed." All decisions pertaining to the design of these hospitals are based on the space, the equipment and the facilities needed for each bed. The quantity and the quality of the medical or surgical service provided by a general hospital are largely determined by the way this particular module is developed into the final design. Increasing or decreasing the number of beds, or the space or services related to each bed, correspondingly increases or decreases the amount of medical or surgical service.

In the case of the general hospital, the "bed module" makes obvious sense, since the work of the professional staff, centered on the patient, takes place in direct relation to the bed to which the patient is assigned. It is obviously unsuitable, however, to serve as the reference module for a psychiatric hospital.

Bed Module Impractical for Mental Hospitals

The mental hospital "bed" is simply and solely a place where a patient sleeps eight hours each night. Little of any therapeutic value, except the ordinary physiological process of sleep, takes place in relation to the bed in the mental hospital. Moreover, there is no more relationship between the number of beds in a mental hospital and the therapeutic service it offers to the community than there is between the number of dormitory beds in a university and the quality or quantity of educational services provided.

In order, therefore, for mental hospital design to make good sense operationally, we must adopt a different unit of measurement—a different philosophical module. The adoption of such a concept as a "psychiatric module" would greatly simplify the design decisions which have to be made. Each new project would be simply some multiple of our basic "psychiatric module."

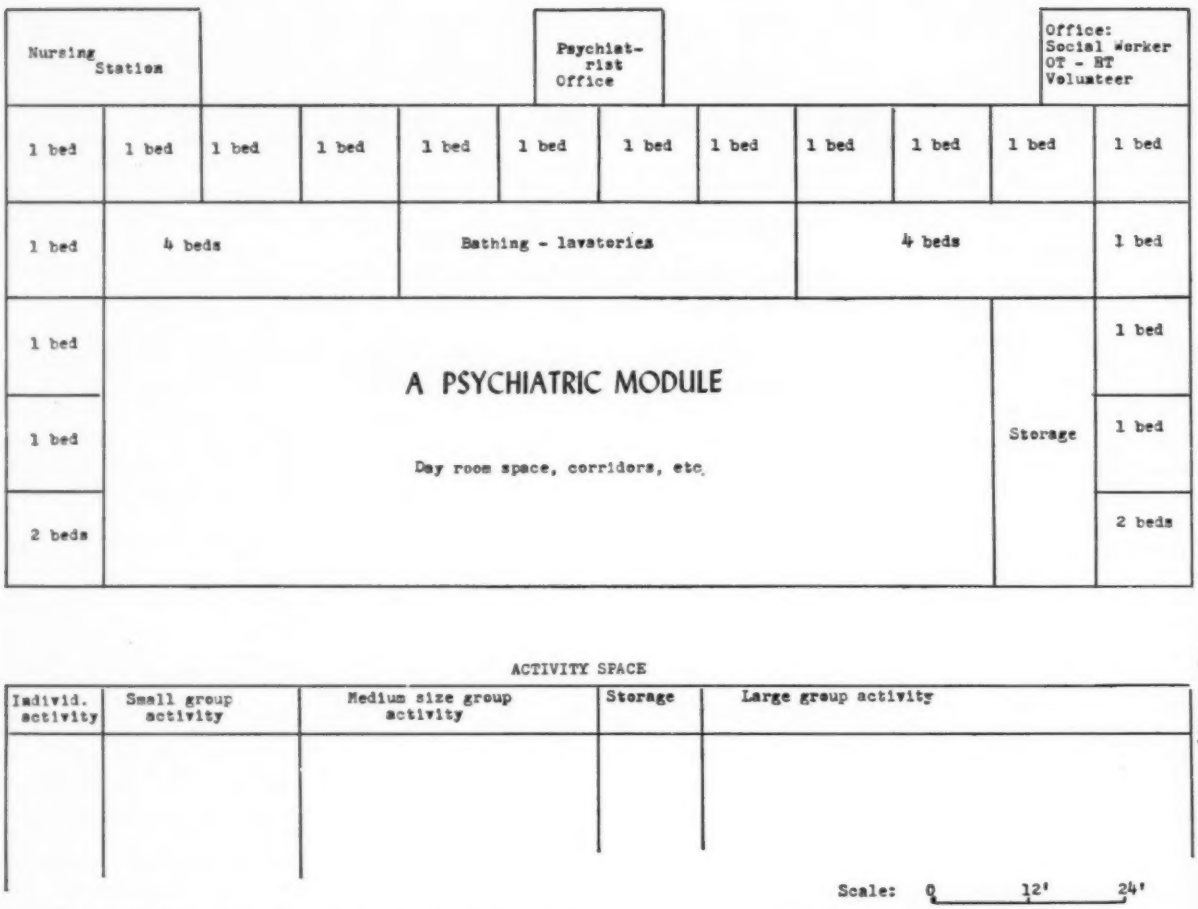
There is no question but that the treatment function of the mental hospital is determined by the therapeutic activities of the professional staff. Since the mental hospital is a medical facility, the ultimate responsibility for treating the patient rests directly on the shoulders of the individual physician, and the therapeutic work of all other personnel must be directed by him and integrated with his treatment program for the patient. The one indivisible unit of mental hospital function, therefore, is the individual psychiatrist. All other therapeutic functions of the hospital will be multiples of his function, and will succeed or fail, be large or small, be good or bad accordingly.

We can, therefore, base our theoretical "psychiatric module" on the psychiatrist. The entire unit of measurement will be the sum total of the personnel activities that he can supervise, the total number of patients he can treat in a working day or week, and the space and facilities he needs to accomplish this.

Theoretical Concept Based on Ideal Situation

In order to illustrate a theoretical concept, specifics must be used, and we will therefore try to define the "measurements" of our psychiatric module in numerical terms. Because this is a theoretical discussion and represents a radical departure from the customary methods of estimating personnel requirements, we have not attempted to make our figures coincide with the A.P.A. Standards, or indeed with any other staffing formula. The same comments apply to the space requirements indicated, which are closer to an ideal situation than to a minimal need.

For the sake of illustration, we will say that a well-trained psychiatrist has as his sole function in the hospital the treatment of relatively new, acute, fairly young patients. He can probably do an adequate job if he has no more than 30 of these patients under his care at one time, especially if not more than one-fourth of them are very recent admissions. If some of these patients are older, more chronic patients who have little in the way of outside prospects to assist them in getting out of the hospital, he could care for a somewhat larger number, but could not handle more than about three new, acute cases per week. If his admission rate is higher, then his discharge rate will fall down, and cases will tend to pile up and make his work inefficient. We might say, somewhat arbitrarily, that he could handle a minimum of 30 acute cases or a maximum of 60 chronic cases, or various combinations of these. Obviously, the more intensive and effective the treatment program is for the acute cases, the fewer will be the chronic cases later on.



Schematic floor plan drawn to scale showing the relative space requirements for one "psychiatric module." According to this concept, a hospital would be seen as a multiple of this plan, plus the necessary auxiliary services.

The doctor's workload will be somewhat as follows: he will spend one hour each day seeing all patients, 15 hours a week seeing each patient individually for a half-hour each time, and 15 hours a week seeing the newer patients for an additional half-hour per week. This will leave him with about 10 hours a week to supervise personnel and take care of various unforeseen situations.

Psychiatrist—Auxiliary Personnel Ratios

The other professional personnel which this psychiatrist can effectively supervise to supplement and complement his work in the care of this group of patients will be approximately as follows:

a. Nurses: It can be assumed that although nursing personnel will remain on duty 24 hours a day, 7 days a week, they will be carrying on a therapeutic function only while the patients are active; when patients are sleeping, the ward personnel have only a custodial function. The nursing supervision needed for our 30 acute cases, 60 chronic cases or various combinations of the two would involve the equivalent of six psychiatric nurses, each on a 40-hour work week. These nurses (or perhaps charge aides) are not, of course, the only nursing service the psychiatrist will need for his patients, but the ward attendants also needed do not affect the space requirements of our psychiatric module.

b. Psychologists: The psychiatrist caring for the above described caseload could make effective use of one psychologist about one day a week, or to put it in another way, one-fifth of a psychologist.

c. Social Workers: One psychiatrist can profitably use three days a week of social service time, which is the same as three-fifths of a social worker.

d. Occupational-Recreational Therapy: The psychiatrist with his given caseload will need the services of one full-time trained activity therapist. Actually, he would use the services of several of these people for shorter periods which add up to the equivalent of one full-time worker.

e. Volunteers: Assuming that volunteers are used to bring a special kind of community contact to the hospital rather than as a substitute for other personnel, one psychiatrist could use 20 hours a week of volunteer time.

f. Administration, Custodial Care and other Services: All the non-therapeutic services of the hospital will be

related to the total patient population, admission-discharge rates, etc. and can only be decided upon when all the therapeutic units are added up.

Translating these personnel quotas into hours per week of personnel time, we can now say that as far as personnel is concerned, a "psychiatric module" is made up of: One full-time psychiatrist, 240 hours of psychiatric nursing time, 8 hours of psychologist time, 24 hours of social work time, 40 hours of OT-RT time, and 20 hours of volunteer time every week.

Space Requirements

a. Patients: Our module's psychiatrist would like about 200 square feet per patient for acute cases and 150 square feet per patient for chronic cases for sleeping, eating, bathing and lounging. This space should be divided so as to provide adequate privacy; at least 50 percent of the acute cases and 25 percent of the chronic cases would have private bedrooms of at least 100 square feet each; not more than four acute cases or over twelve chronic cases would be in any one bedroom. At least 40 percent of the ward space would be available as day room space.

b. Psychiatrist's Office: The doctor, our "indivisible unit," will need a standard office not less than 120 square feet in area.

c. Nursing Stations: One nursing station will be needed for 30 acute or 60 chronic cases. Office space of at least 100 square feet and another 100 square feet for refrigerator, supplies, etc. should be included.

d. Auxiliary Personnel Office Space: For the psychologist, the social worker, the OT-RT personnel, the equivalent of one full-time office, at least 120 square feet in area, is needed.

e. Activity Area: Space must also be provided for recreation, occupational and other activity therapies, geographically independent of the patients' living area. Of course, the entire activity space will be shared by all the other groups of patients of the hospital. The group we are using as an example, though, will require a minimum of 600 square feet of space for full-time use, to be broken up into units of various sizes suitable for individual, small group, and large group participation.

f. Medical Dispensary: Ordinary clinical medical facilities will be needed, with X-ray, laboratory, dental units, etc. Here the module used *is* the "bed unit" and facilities to serve one bed per hundred patients will be needed, depending largely on the age grouping of the patients, since obviously the older age groups need more medical care.

g. Administrative and Other Services: No direct proportion exists between the space needed for these functions and the units already described; the size must be decided on independently and flexibly.

As far as building design is concerned, therefore, our "psychiatric module" will consist of the space and equipment which one psychiatrist and his auxiliary therapeutic personnel need in order to conduct an effective treatment program for 30 acute or 60 chronic patients, or various combinations of these two. Taking only the example of the 30 acute cases (and this would particularly apply to the design of an acute, intensive treatment unit), the space requirements would be: 440 square feet of office and nursing station space, 6000 square feet of ward space for patients, and 600 square feet of activity therapy space, furnished and equipped appropriately, making a total of 7040 square feet. The various non-medical services (food, administration, heat, storage, laundry, etc.) would not be proportionately related to this module, and could be decided on only after all the modules are added up, and many other factors taken into account. If, for example, patients are used to provide labor for the laundry, about twice the facilities will be needed, because of inefficiency, as would be needed if employes alone were used. The same would apply to food services.

At present rates, the cost of constructing the psychiatric module described, not including the auxiliary services, would be about $140,000. On this basis a new acute intensive treatment unit designed to serve the needs of a psychiatric staff of six would be about $840,000. With all the auxiliary services included the total cost would be about $1,200,000. Such a unit, properly staffed, could supply all the mental hospital needs of a community of 500,000 population, assuming there are adequate non-hospital resources such as mental hygiene clinics and psychiatrists in private practice.

The number of psychiatric modules making up the total hospital size in a given area would depend entirely on the number of competent psychiatrists and other therapeutic personnel who can be recruited. This number will almost invariably be less than hoped for. It is suggested that the total size be made flexible in the sense that construction be carried out in stages, the second stage not being started until the first section has been staffed adequately. This will usually mean the planning of the different stages of the hospital in units of five modules each. The chances of any new mental hospital ever recruiting more than fifteen personnel units (that is, fifteen psychiatrists plus corresponding numbers of other personnel) are very remote.

Recent Publications of Interest to Mental Hospitals

PAINT MANUAL U.S. Bureau of Reclamation
U.S. Govt. Printing Office, Washington, D.C. ($1.25)
—Presents types of paints suitable for different types of surfaces.

PAINT MANUAL Corps of Engineers, U.S. Army
U.S. Govt. Printing Office, Washington, D.C. (74c)
—Govt. specifications for new construction.

PAINT SPECIFICATIONS
E.I. du Pont de Nemours and Co., Wilmington, Del.
—General description and specifications for paints.

DEVELOPMENT OF FIRE RETARDANT PAINTS AND PAINT SYSTEMS
Corps of Engineers, U.S. Army, Office of Technical Services, Washington, D.C. ($3.25)
—Technical report of the newest developments in paints which withstand high temperatures.

QUARTERLY PROFESSIONAL CALENDAR

A.P.A. ANNUAL MEETING

1959 April 27-May 1, Municipal Auditorium, Philadelphia
1960 May 9-13, Convention Hall, Atlantic City

A.P.A. MENTAL HOSPITAL INSTITUTE

1959 Oct. 20-22, Hotel Statler, Buffalo, N.Y.
1960 Oct. 17-20, Hotel Utah, Salt Lake City
1961 Oct. 23-26, Hotel Fontenelle, Omaha, Neb.

Other Meetings, January, February, March, 1959:

AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION, Jan. 23-24, New York City

ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOANALYSIS, Jan. 28, New York City.

11TH INSTITUTE IN PSYCHIATRY AND NEUROLOGY, Feb. 26-27, VA Hospital, Little Rock, Ark.

AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, Mar. 30-Apr. 1, San Francisco, Calif.

State Commissioners Organize

State commissioners and equivalent directors of twenty-nine state mental health and hospital programs have announced their intention of organizing as a permanent national group to exchange information about their programs and how they may be further advanced.

Meeting in Kansas City, Mo., under the auspices of the A.P.A. during the Tenth Mental Hospital Institute, the attending commissioners designated themselves a Committee of the Whole pending final formation of the organization. State commissioners not present at the Kansas City meeting are being invited to participate.

An executive steering committee appointed to work out the details of organization consists of: Dr. George W. Jackson, Kansas, Chairman; Dr. Clifton T. Perkins, Maryland, Vice-Chairman; Dr. Harold L. McPheeters, Kentucky; Dr. Hayden H. Donahue, Oklahoma; Dr. Granville L. Jones, Arkansas; Dr. Addison M. Duval, Missouri; Dr. Cyril J. Ruilmann, Texas; Dr. John E. Davis, Jr., Pennsylvania; Dr. Earl K. Holt, Jr., New Hampshire; and Dr. John B. K. Smith, Alaska.

This committee is already actively at work formulating draft statements of constitutional objectives, bylaws, etc., and planning an agenda for the next meeting, the date for which is to be announced. The steering committee is also devoting its attention to the selection of an appropriate name for the new organization.

At their meeting in Kansas City the commissioners indicated their intention to enlist the assistance of the A.P.A. and to collaborate with it in every feasible way. The A.P.A. Council at its meeting in November applauded the formation of the commissioners' organization and authorized the Medical Director to cooperate fully with the group.

State Governors who have been informed about the impending organization have been virtually unanimous in welcoming it as a reinforcement of their efforts to advance mental health programs.

N.Y.C. Supports Medical Research

With the creation of the Health Research Council of the City of New York, and the allocation of $600,000 to finance its initial year, New York City lays claim to being the first municipality in the United States to subsidize medical and health research, including psychiatric research. Dr. Harvey J. Tompkins, Director of the Reiss Mental Health Pavilion of St. Vincent's Hospital of the City of New York, has been appointed as the only psychiatrist to serve on the council.

Realizing the tremendous research potential of local resources under both government and private auspices, New York's Mayor, Robert F. Wagner, concluded that an over-all research council was necessary to mobilize these resources for the betterment of the total health of the city. Accordingly, he appointed a group of prominent citizens and eminent scientists to make up the Health Research Council, which has as its prime function the formulation of research programs aimed toward solving the health and medical problems of the City of New York.

Another and very important function of the council is to encourage gifted young people to enter the field of medical science, particularly in the research aspects, and enable them to remain in the field. The Mayor hopes within the next four years to increase the initial allocation of $600,000 to $1 per capita, or roughly three per cent of the city's current budget for health protection and medical care.

The plan does not duplicate any existing research support program or facility in the city. It is a city-sponsored program created specifically by the Mayor to promote and increase scientific research into the city's health problems.

Fire Damages Canadian Health and Welfare Building

An explosion and fire originating from a gas leak in a building across the street seriously damaged the offices of the Mental Health Division of the Department of National Health and Welfare in Ottawa in November.

Fortunately, the accident occurred on a Saturday when few people were at work in either building and no one from the department was injured. However, the damage to records and files was considerable and the division had to delay until December putting out the November issue of its publication, CANADA'S MENTAL HEALTH.

We are informed by Mr. Carl Birchard, editor, that the December issue was omitted entirely and the January and February issues will be combined in one. Thereafter it is anticipated that publication will progress on schedule.

HAVE YOU HEARD?

PATIENTS' ACTIVITIES: *The Spokesman*, a weekly paper run entirely by the patients of **Rochester (N.Y.) State Hospital,** features not only material written by the patients themselves but also articles by the staff, such as the candid report by the assistant director on the open door policy. It is also interesting that local merchants advertise in *The Spokesman*. Although not connected with the Occupational Therapy Department, the paper is a form of occupational therapy in which patients, some of whom have had experience in journalism, advertising and art, obtain a great deal of satisfaction. It gives them a sense of responsibility since hospital personnel act only as consultants. The work helps them strengthen their hold on reality.

Newberry (Mich.) State Hospital has a horticulture project whereby patients learn to cultivate and arrange flowers and make corsages for the local florists.

COMMUNITY RELATIONS: Fifty-one patients of **Greystone Park (N.J.) State Hospital** are enrolled this year in a course in public speaking. Conducted by the Morristown Speakers Club and professional men from Dale Carnegie Inc., the ten-week course is held under the supervision of the hospital's recreation department and has attracted many patients in the past.

A radio station in Fergus Falls (Minn.) is promoting hospital-community relations by including in its daily "Local News" broadcast a report of functions at the **Fergus Falls State Hospital.** These reports, taken from the institution's paper, include activities scheduled for the day and give the general public an idea of what goes on at the hospital and what is being done for the patients.

A new service for patients at **Willmar (Minn.) State Hospital** has been initiated by the Volunteer Council. It consists of a "welcome packet" which is presented to each patient. This expansion folder contains a pencil, stationery, postage stamps, a calendar and an address book. It also provides a handy place to store received letters. It is personalized with the patient's name and carries the following message printed on the front: "This correspondence folder is a gift from the Volunteers of the community, who wish you a short stay at the hospital."

On December 10 the Armstrong Circle Theatre's TV presentation was an hour-long documentary film on the **Glenwood (Iowa) State School,** with professional actors portraying staff and patients. Mr. Alfred Sasser, superintendent of the school, spoke briefly at the end of the program.

TRAINING AND RESEARCH: A marked increase in grants to support the training of skilled workers in the field of mental health was reported recently by Dr. Robert H. Felix, Director of the **National Institute of Mental Health.** Grants to date in this fiscal year total over $16 million, compared to $13 million in the last fiscal year. This year, for the first time, money has been available to support training of research-oriented psychologists at the doctoral level with emphasis on child development as well

as psychological and social development in the human personality.

Mansfield (Conn.) State Training School and Hospital has announced the receipt of a $60,000 grant for a three-year continuation of research on the learning process of mentally retarded children. The principal objective of the study is to discover what new instructional techniques can be developed for these children.

St. Peter (Minn.) State Hospital has instituted a "buddy" system by which visiting nursing students from other institutions are taken in tow by student nurses of the host hospital. Visiting students are first given a brief orientation, then a tour of the premises. At this point, each St. Peter's student selects a visiting student who then follows her around for the rest of the morning. At noon, they have lunch together and go to a classroom for a question-and-answer period. This method has proved quite successful in that it promotes a free exchange of ideas and comparisons between the different affiliate psychiatric nursing programs.

CONSTRUCTION: Dedication services of a synagogue and a Protestant chapel took place at the **St. Lawrence State Hospital,** Ogdensburg, N.Y., on November 16. A Catholic chapel was built some 50 years ago. Thus each of the three major faiths now has its own house of worship.

Preliminary plans for the new building of the **National Library of Medicine** have been submitted to the Public Buildings Service. The 85th Congress appropriated $7 million for this building. The construction is due to be started in the spring on the grounds of the National Institutes of Health in Bethesda, Maryland.

Ground was broken recently in **New York** for two new state institutions—a hospital for the mentally ill in the Bronx and a school for the mentally retarded at West Seneca in Erie County.

Gracie Square Hospital, a newly completed building in New York City, is now accepting private and semi-private psychiatric patients for emergency treatment around the clock. All recognized forms of treatment are available in the 232-bed hospital, which also has facilities for narcotic addicts and alcoholics. It maintains a day and night program for outpatients and a geriatric service.

Scheduled ultimately for a 4,000 patient capacity at a total cost of approximately $30,000,000, **Fairview State Hospital** for the mentally retarded, Costa Mesa, California, will have slightly in excess of 1,600 beds available when it goes into operation this month.

ACTIVITY THERAPISTS will be interested in knowing that **Buffalo (N.Y.) State Hospital** has the largest catalogued library—over 900 volumes—of occupational therapy publications. (This was gleaned from a C.I.B. report.)

People & Places

HERE & THERE: **Dr. Leabelle I. Ross** has been appointed acting superintendent of the Juvenile Diagnostic Center in Columbus, Ohio. **Dr. Roger M. Gove,** its former superintendent, became head of Columbus State School.

Dr. Lauretta Bender, principal research scientist in child psychiatry for the N.Y. Department of Mental Hygiene, has been named Medical Woman of the Year by the Women's Medical Society of New York State.

Dr. Milton E. Kirkpatrick has retired as director of the Greater Kansas City Mental Health Foundation. He is succeeded by **Dr. Robert H. Barnes.**

Dr. Allen W. Byrnes left the VA Hospital at Danville, Ill., to become director of professional services at the VA Hospital, St. Cloud, Minn.

Dr. Edgar C. Yerbury, superintendent of Connecticut State Hospital, Middletown, retired on Jan. 1. **Dr. Harry S. Whiting** has been named acting superintendent.

The National Association of Private Psychiatric Hospitals recently elected **Dr. Benjamin Simon** of the Ring Sanatorium, Arlington Mass. as president and **Dr. Perry C. Talkington** of Timblerlawn Sanitarium, Dallas Tex. as secretary. For the first time, the Association now has a full-time executive secretary, **Mr. Melvin Herman.**

Dr. Paul H. Hoch has been reappointed by Governor Rockefeller as Commissioner of Mental Hygiene for New York State.

DEATHS: **Dr. Eugene E. Elder,** former superintendent of Woodside Receiving Hospital, Youngstown, Ohio, on Oct. 2, in Miami Fla.; **Monsignor Joseph B. Toomey,** president-elect of the Catholic Hospital Association, on Nov. 10, in Syracuse N.Y.; **Dr. Joseph L. Gilbert,** staff member of St. Elizabeths Hospital, Washington, D.C., on Nov. 13; and **Dr. Rawley E. Chambers,** former assistant director for Program Development of the Board for Texas State Hospitals and Special Schools, on Nov. 14, in Texas.

CURRENT STUDIES

This column lists reports on investigations of interest to mental hospitals. Authors have agreed to make copies of their papers available, and requests should be sent to them directly, with 25¢ for postage and handling (unless otherwise indicated). The editor wishes to point out that these studies have not been evaluated by the A.P.A.

REPORT ON VISIT TO ENGLISH HOSPITALS. L. J. Meduna, M.D., Department of Psychiatry, Neuropsychiatric Institute, 912 South Wood Street, Chicago 12, Ill.

MAINTAINING PATIENTS RELEASED FROM MENTAL HOSPITALS IN THE COMMUNITY. Else B. Gris, M.D., Principal Research Scientist, Department of Mental Hygiene, Research Unit, 2 W. 13th Street, New York 11, N.Y.

"THE RETURN TO EFFECTIVENESS OF HOSPITALIZED MILITARY PYSCHIATRIC PATIENTS. Lucio E. Gatto, Colonel, USAF (MC), Deputy Commander Consultant in Psychiatry, USAF Hospital, Keesler Air Force Base, Mississippi and Dr. Ralph Long.

THE ROLE OF THE PATIENT IN A THERAPEUTIC COMMUNITY, PRINCIPLES AND PRACTICAL CONSIDERATIONS. Alexander Gralnick, M.D., Director, High Point Hospital, Port Chester, N.Y.

DISCHARGES FROM MENTAL HOSPITALS. Sidney L. Sands, M.D., Suite 300, Des Moines Building, Des Moines 9, Iowa. Accepted for publication in the American Journal of Psychiatry.

How the C.I.B. Rates the Dietary Department

by CHARLES K. BUSH, M.D.
Chief Inspector

THE A.P.A. CENTRAL INSPECTION BOARD rates hospitals on twenty-nine departments, nine of which are considered "essential." These departments are Administration; Clinical and Pathological Laboratories; Dietetics Department; Facilities for Patient Care; Medical Records; Medical Staff Organization; Nursing Service; Physical Plant; and X-ray Department.

For a hospital to be "Fully Approved" it must have a general average of 70 or more points over-all and must have 70 or more for each department in the "essential" list—except for Medical Staff Organization and Nursing Service which must each rate 75 points. Hospitals having an over-all average of 60 to 69 points will be "Conditionally Approved" provided that not more than three departments in the "essential" list fall below 70 and also provided that the Medical Staff Organization and Nursing Service do not fall below 60 each. Conditional approval continues for three years. Even if a hospital receives full approval, the Board in its report calls attention to items which need improvement and makes recommendations as to how this may be effected.

The following paragraphs describe what we look for in our inspection of one of the "essential" departments, Dietetics, and give an idea of what is necessary to make a dietary department acceptable according to our standards. In subsequent issues of MENTAL HOSPITALS we will take up other "essential" departments.

The rating of the dietary department is divided into seven categories which can score the maximum points indicated: Personnel 30; location 10; adequate space 10; adequate equipment 16; adequate diet and service 20; good housekeeping 4; records and reports 10.

Personnel

The single item that rates the most points in all categories is a well-trained, qualified dietitian who belongs to the American Dietetic Association and is an able administrator. If such a person is at the head of this department and is given sufficient freedom to run it properly, we feel that the department is on a firm foundation. We prefer that the dietitian be responsible to the medical superintendent or assistant medical superintendent, since food is often a medical problem and not all business managers understand the importance of dietetics. The dietitian should be responsible for the selection of food items to be ordered, meal planning, food preparation, cooking and serving.

Depending on the size of the hospital, there should be one or more assistant dietitians who should be in training for top jobs in the field. There should also be an adequate number of cooks, cooks' helpers, dining-room supervisors, butchers, bakers and food-service helpers. Patient help should be used only in routine work and where there is adequate supervision. The service of food on the wards should be the responsibility of the dietary division and should not be delegated to the nursing service. Bedside feeding, however, should always be handled by the nursing service.

In order to obtain properly qualified people and, more important, to keep them, hospitals need to provide them with remuneration equal to that paid in other hospitals or in industry. Poor wages and poor working conditions usually cause a large turnover in the dietary service. There should be an inservice training program for all personnel and this should include instructions regarding mental illness and patient problems as well as material pertinent to the work of the individuals. The training program should be a continuing process with at least one hour of classwork weekly.

Location and Space

It is important that the kitchens, dining-rooms, serving kitchens, diet kitchen, bakery, butcher shop and storage areas be satisfactorily located with relation to each other and to other buildings. It is equally important that there be adequate space in each area to insure good working conditions and work flow. Kitchens should be of such construction that they can be easily and thoroughly cleaned. Quarry tile usually makes the most satisfactory floor and an acid-resistant mortar is now on the market which is not affected by food spilled on it. Ceramic tile makes an excellent wall surface. Ceilings should be of acoustic tile, which is now available in material which is not affected by steam. Forced ventilation should be used in this area. Adequate refrigeration space should be provided for all different types of food, and also for garbage if garbage grinders are not used. The interior of the refrigerators should be a hard surface that is easily cleaned.

Dining-rooms should be as close to the kitchens as possible. They should be light, well ventilated and cheerful. Floors and walls should be of easily cleaned materials

* *From time to time on these pages MENTAL HOSPITALS will carry articles describing A.P.A. functions which are particularly pertinent to the operations of psychiatric hospitals.*

and the ceiling should be acoustically treated. Dining areas should be large enough to seat all patients at one or two seatings without crowding. All dining-rooms should contain a water cooler.

Toilets should be provided for dietary personnel and for patients, and hand-washing facilities should be adjacent to the toilets.

Diet and Service

The regular diet should be adequate and nourishing and based on a standard ration allowance. Special diets should be carefully prepared by qualified personnel, and should be served only on a physician's prescription. Written menus should be prepared at least one week in advance and monotony should be avoided. Foods purchased should meet carefully written specifications, and inferior foods should be rejected.

All food should be carefully handled by food tongs or other instruments rather than by hand. Equitable portions should be served each patient and a dietitian or supervisor should be stationed at the end of the serving line to assure that each patient has been properly served. Plates for hot foods should be warmed and food items should not be mixed or piled up.

Condiments should be available on the tables and sugar and cream should be provided for coffee. Except where definitely contraindicated, china or plastic dishes and full sets of tableware should be used. Metal dishes or paper dishes may be substituted for those patients who are destructive or combative. Each patient should have a napkin, either cloth or paper, and tableware should be wrapped in the napkin. When table service is used, the food should not be placed on the tables before the patients have entered the dining-room.

Patients should not be rushed in the serving line or while they are eating. Traffic to and from the dining-room should not cross.

Unless employees and patients are served identical menus, it is recommended that employees' meals be handled entirely separately from patients' meals. This can usually be done by having the canteen or a concessionaire furnish employees' meals from entirely separate supplies of foods.

Equipment

Kitchens should contain equipment for all different types of cooking. In addition to steam kettles, there should be provisions for baking, for frying and also for broiling. Food preparation areas, which should be adjacent to the kitchen, should have the necessary equipment for potato peeling, slicing, etc., and the equipment should be kept in good working condition. Mixers and other equipment in the kitchen should be inspected daily to be sure that they are in proper working order. Adequate storage space should be provided and all bins and containers for bulk food should have tight-fitting covers. Storage areas should not be used as dressing rooms or a place for hanging clothing. A lounge for this purpose should be provided for each sex.

Dining areas should be equipped with small tables, preferably to seat four. This gives the patient a chance to choose his table companions and increases sociability. Table tops should be smooth and without cracks, so that they can be easily cleaned. Chairs should be comfortable and many hospitals have made them attractive by using bright colored covers. Food may be served cafeteria style or by table service. The former is preferred for all patients capable of cooperating. The latter is useful for smaller groups if enough well-trained waiters are available. Cafeteria counters should contain a cold bainmarie, a steam table, liquid dispensers, toasters, and equipment for cooking eggs, waffles and hot cakes.

Clean-up rooms, located between the dining-rooms and the dishwashing areas, should be so arranged that liquids are emptied first, then solid waste can be emptied into garbage grinders or garbage cans. At this point, the amount of waste should be noted by a responsible employee and reported to the dietitian.

Dishwashing machines should be checked at regular intervals to be sure that the water is hot enough and that dishes are being properly cleaned and sterilized. The dietitian should be sure that dishes are being left in the dishwasher for the required period of time. Adequate storage space should be provided for clean dishes where personnel are able to reach them without having to resort to a footstool or stepladder.

Serving rooms or serving kitchens should contain a refrigerator, dishwasher, toaster, grill and cupboard for dishes. Food served on wards should be transported in heated food carts. Speed of transportation and immediate serving is of the utmost importance. Too often, good food is purchased and properly prepared, but when it reaches the patient, it is unpalatable because the temperature has not been controlled. Hot foods should be served hot, and as soon after cooking as possible. Eggs, toast, waffles and hot cakes should be prepared in the serving kitchen immediately before serving.

Housekeeping

It would seem unnecessary to have to point out that all dietary facilities should be kept clean and sanitary. Yet lack of sanitation is one of the adverse points most frequently noted in our reports. Sometimes we are amazed that there have not been recurrent outbreaks of gastroenteritis.

All equipment and utensils should be carefully cleaned daily. Walls and floors should be cleaned as often as is necessary to keep them spotless. All areas should be carefully screened and if flies enter, they should be eliminated at once. Insects and rodents should be completely controlled and kitchen and dining areas should be checked regularly between 10:00 p.m., and midnight. If roaches seem hard to eliminate, check the electric clocks in the kitchens and dining-rooms (not to see whether inspections are being made on time but rather to observe whether roaches are living in the clocks because of the warmth generated by the electricity).

If mops are used, they should be hung outside to dry except in freezing weather. Mops should always be hung with the heads down so that the excess water will not drain down the handle.

All dietary personnel should have a physical examination every six months, including chest X-ray, throat culture and stool examination. In addition, food handlers

should be checked by the supervisor when they go on duty each day to see that they have no skin infections or upper respiratory infections.

Samples of each meal should be saved for a 24-hour period under refrigeration so that the source of any gastroenteritis may be quickly determined by the laboratory.

Records and Reports

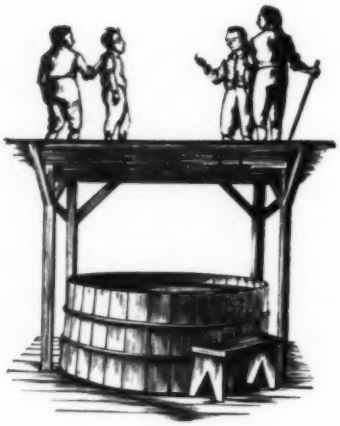
As previously noted, a standard ration allowance should be set up and records kept to show that the foods served meet this standard. Complete records should be kept of food costs, food consumption and food waste. Monthly reports of these items should be submitted to the superintendent.

In order that the organization shall function smoothly, regular staff conferences should be held and even the helpers should be invited occasionally to attend.

If the hospital has a farm which produces food products, or if surplus commodities are received by the hospital, adequate canning, freezing and storage facilities must be provided for them. This will eliminate repetitious meals planned merely to use up food before it spoils.

Correction

In the December issue of MENTAL HOSPITALS the name of The Gateways, Los Angeles, was inadvertently omitted from the list of private hospitals approved by the Central Inspection Board at their meeting on October 30. The total number of private hospitals now approved was correctly stated as twelve.



"Surprise Bath" used in colonial times to "restore the distracted to their senses." Original wood engraving by John De Pol.

to restore them to t

Less than 200 years ago, the mentally ill were bled, purged, beaten and sometimes nearly drowned in efforts to restore them to their senses.

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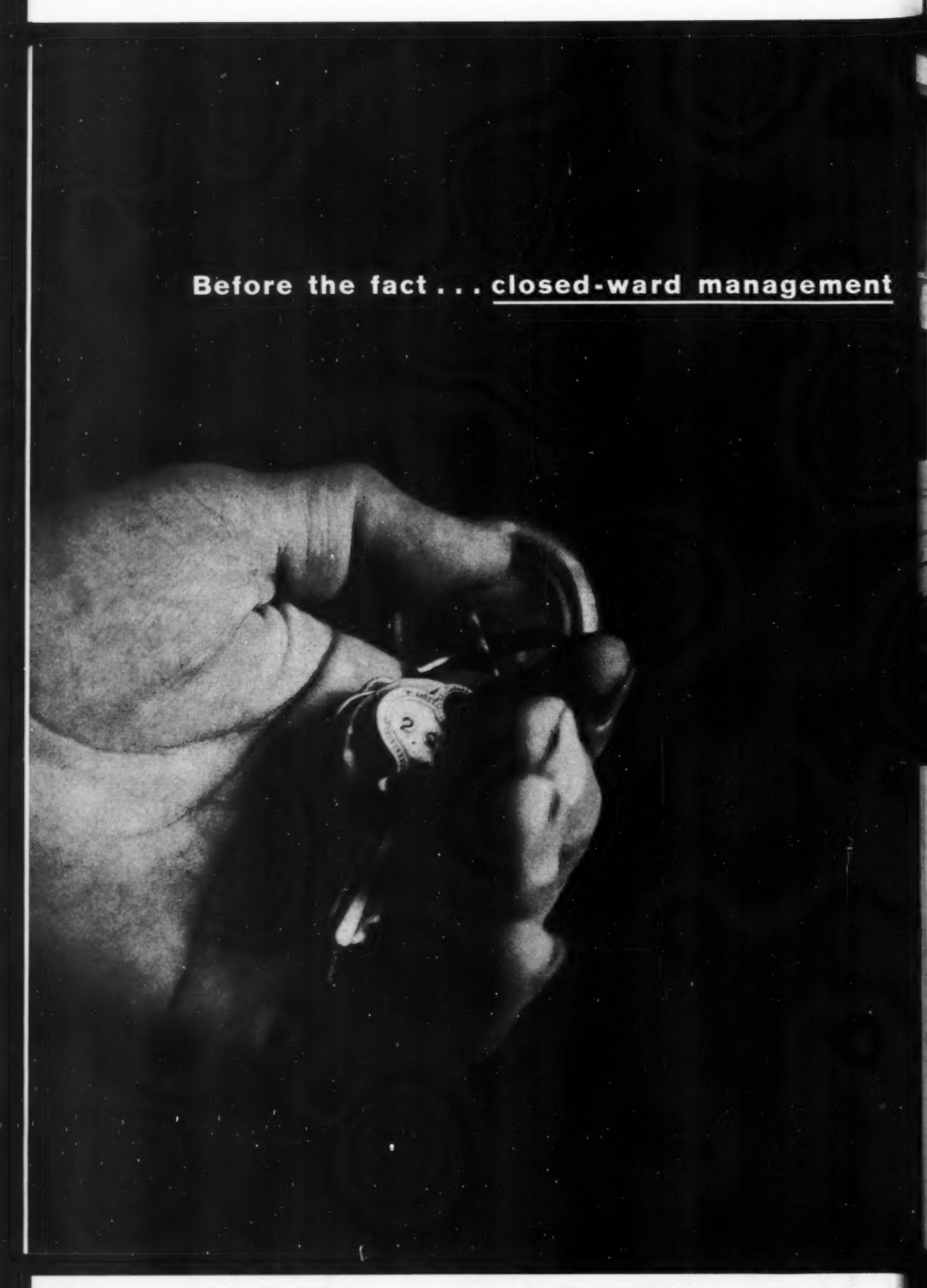
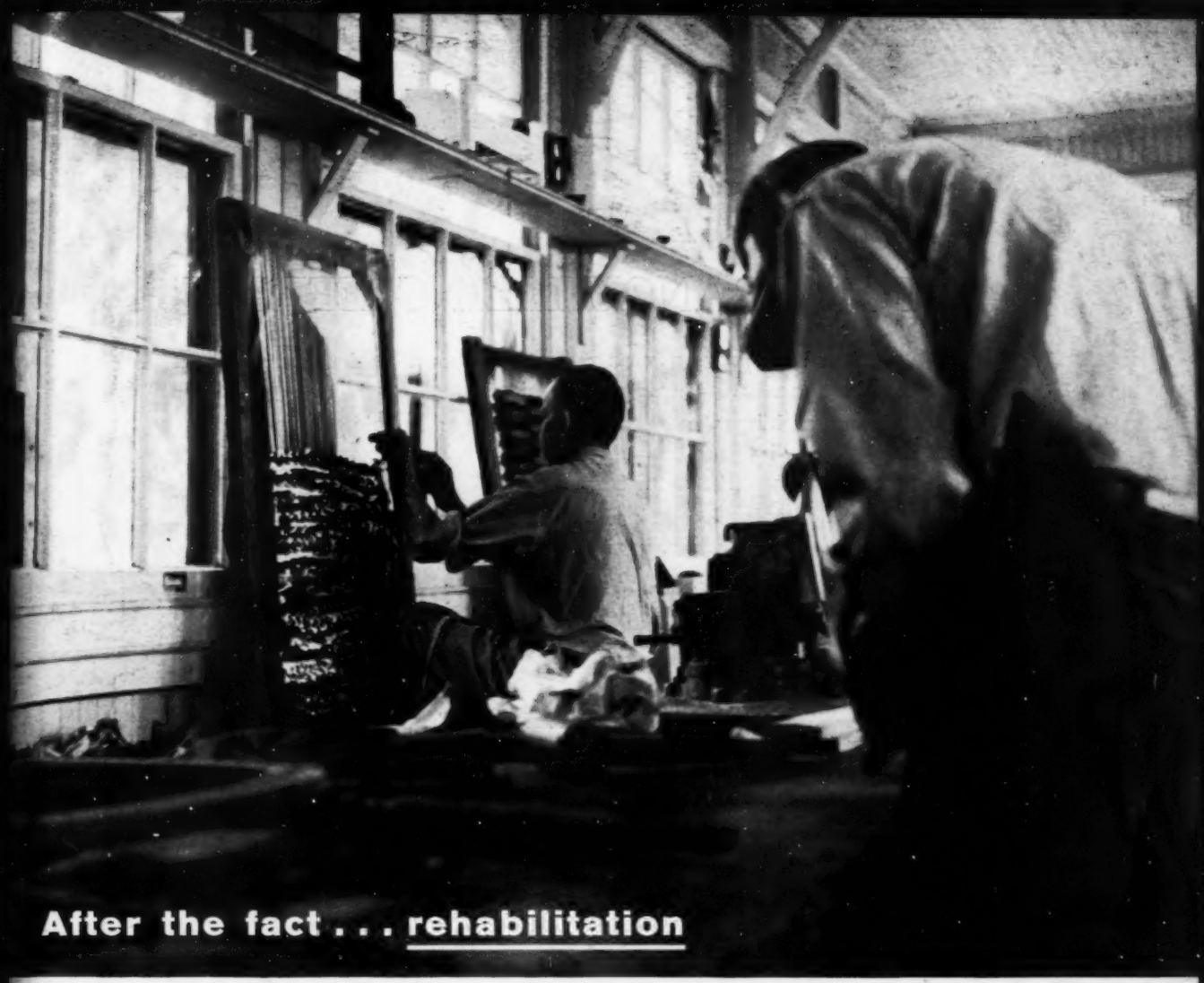

Before the fact . . . closed-ward management



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References: **1.** Barsa, J. A.: Am. J. Psychiat. **115**:79, July 1958. **2.** Graffagnino, P. N., Friel, P. B. and Zeller, W. W.: Connecticut M. J. **21**:1047, Dec. 1957. **3.** Hollister, L. E., Elkins, H., Hiler, E. G. and St. Pierre, R.: Ann. New York Acad. Sc. **67**:789, May 9, 1957. **4.** Pennington, V. M.: Am. J. Psychiat. **114**:257, Sept. 1957. **5.** Tucker, K. and Wilensky, H.: Am. J. Psychiat. **113**:698, Feb. 1957.

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